

APPLICATION FORM FOR ASSISTANCE (Healthcare)			(सहायता हेतु आवेदन प्रारूप) (स्वास्थ्य देखभाल)	
APPLICATION No.: K/0119/ 2799			APPLICATION DATE: 24/04/19	
NAME of APPLICANT: LAKSHMI RANI DEBNATH			AGE-YEARS: 68	SEX: F
FATHER'S/SPOUSE'S NAME: SHATISH CHANDRA DEBNATH				
PRESENT RESIDENCE ADDRESS: MATIHAN BLOCK, RAJPUR SONARPUR, CHAKHAN SOUTH 24 PARAGANAS HOOLA, WEST BENGAL.				
PERMANENT RESIDENCE ADDRESS: - AS ABOVE -				
OCCUPATION: HOME MAKER.			MARRIED (विवाहित) / UNMARRIED (अविवाहित)	
TOTAL ANNUAL INCOME: NIL			(Attach Proof of Income) (आप का साक्ष्य संलग्न करें)	
PAN No. (यदि खाता संलग्न करें)			Yes / No	
ARE YOU AN INCOME TAX ASSESSEE (Tick whichever is applicable):			Yes / No	
FAMILY DETAILS परिवार विवरण				
Sr. No. क्रम संख्या	Name of Family Member परिवार के सदस्यों का नाम	Age (Years) उम्र (वर्ष)	Gender लिंग	Relation with Applicant आवेदक के साथ सम्बन्ध
1	LAKSHMI RANI DEBNATH	68	F	SELF
2	ASTHA DEBNATH	36	F	SON
3	ANUP DEBNATH	15	M	SON
4	AJOK DEBNATH	37	M	SON
BASIS for REQUESTING ASSISTANCE (Tick whichever is applicable) सहायता के लिये विधि आधार				
BPL Card (Attach Card Copy) गरीबी रेशा के नीचे प्रमाण पत्र (प्रमाण पत्र की छापी प्रति संलग्न करें)		EWS Certificate (Attach Certificate Copy) अल्प आय वर्ग प्रमाण पत्र (प्रमाण पत्र की छापी प्रति संलग्न करें)		Any Other Basis/Proof अन्य कोई साक्ष्य
"PURPOSE" for REQUESTING ASSISTANCE: सहायता हेतु किसे मने चिकित्सी का उद्देश्य:				
Sr. No. क्रम संख्या	Medical Reports/Prescriptions Attached अस्पताल/डॉक्टर से जारी की गई इतिवेदन सूची संलग्न			
1	DIAGNOSIS- CATARACT- LE			
2	SURGERY LE (SUCCESSFUL)			
ASSISTANCE BEING AVAILED for SAME "PURPOSE" from OTHER SOURCES इस उद्देश्य के हेतु कोई अन्य सहायता किसी अन्य स्रोत से लिये गया है?				
Sr. No. क्रम संख्या	NAME of OTHER SOURCE अन्य स्रोत का नाम	AMOUNT of ASSISTANCE BEING AVAILED सी गई सहायता राशि		



DECLARATION by APPLICANT: ☐ YES ☐ NO ☐ N/A

- 1) I hereby confirm that all details in this Form are True to the best of my knowledge. Any false statement will render my Application & ongoing assistance, if any, liable for rejection/cancellation.
- 2) I solemnly confirm that assistance, if received from Koshika Foundation, will be used only for the "purpose", as stated in this Form, for which such assistance was requested by me.
- 3) I hereby confirm that I have not & will not in future, avail of reimbursement, in part or in full, from any other source/employer/insurance company, of the amount for which this assistance is requested.
- 1) मैं यहाँ पर कतार है कि इस प्रकरण में मैंने मेरे सभी विवरण मेरी जानकारी के अनुसार सत्य एवं सही हैं। यदि कोई विवरण सत्य कथन प्रमाण पत्र यात्रा है तो मेरी सहायता प्राप्त की जा सकती है।
- 2) मैं यहाँ पर कतार हूँ कि "कोशिका फाउंडेशन", से ली जा रही है, सहाय प्रमाण पत्र प्रमाण पत्र के तहत मैंने सहायता प्राप्त की है।
- 3) मैं यहाँ पर कतार है कि मैंने सहायता प्राप्त की है, इस प्रमाण पत्र के तहत मैंने सहायता प्राप्त की है।

AGREEMENT by APPLICANT (above sig line)

- 1) By affixing my signature or thumb impression on this Form, I (Applicant) hereby agree & authorise Koshika Foundation and it's Trustees to receive/publish/put-up/reproduce my name, address, photo & details of the "purpose", for which such assistance is requested/granted, through any medium, including but not limited to verbal, print, electronic, for soliciting donations for Koshika Foundation and/or disseminating information about it's activities/achievements. Such use of my photo & details can be made by Koshika Foundation before or after my treatment or fulfillment of the "purpose" for which assistance is being requested.
- 2) I (Applicant) further agree that any such use of my name, address, photo & details of the "purpose", for which such assistance is requested/granted, will not automatically entitle me for receiving or continuing the said assistance. The decision for granting and/or continuing the assistance will rest solely with the Trustees of Koshika Foundation, and their decision in this regard will be final and acceptable to me.

APPLICANT'S SIGNATURE OR LEFT THUMB IMPRESSION :

andrew at russell on april 20 2009



AGREEMENT by HOSPITAL (EVEN IF NOT)

By affixing hereunder, signature of our Authorised Signatory for recommending this case/patient for financial assistance from Koshika Foundation, we (Hospital) hereby affirm & accept following:

- 1) that we neither are presently nor will in future avail of financial assistance from another NGO or any other source, for the same patient/case, as we are requesting to get from Koshika Foundation, to the extent that such assistance is granted by Koshika Foundation. If the requested assistance is not granted by Koshika Foundation, in part or in full, then the Hospital reserves its right to make up the shortfall from another NGO or any other source. This confirmation essentially states that the Hospital will not avail any duplicate assistance for the same patient/case from any other NGO or any other source.
- 2) The assistance from Koshika Foundation is only financial in nature. The choice of the treatment/procedure advised/conducted by the Hospital on the patient, is based on the arrangement between the patient & the Hospital, and is in no way influenced by Koshika Foundation. Hence, the Hospital will assume sole & complete responsibility of the treatment & its outcome & safety of the patient, and Koshika Foundation will have no role or responsibility in the matter.

RECOMMENDED FOR ACCEPTENCE

सन्धीकृताते नडे नितर संपत्तुति

Date of Surgery
सर्जरी की तारीख

अभिनेता की शक्ति,
अभिनेता की शक्ति

24/04/19

(Name of District Health. No. with Stamp)

(Name, Designation & Stamp of Authorised Signatory
on behalf of Hospital)
नाम व पद हस्ताक्षर अधिकृत अधिकारी

नाम व पद इत्यादित् अधिष्ठत अधिकां

FOR INTERNAL USE of KOSHIKA FOUNDATION

अन्योन्य उपपन्नं द्वयं

SIGNATURE of TRUSTEE 1

न्यायी इत्यादि ।

Sefernyel

SIGNATURE of TRUSTEE 2

म्यासी इन्स्टाण्डर 2

2028