

C/19/04/0498

APPLICATION FORM FOR ASSISTANCE

सहायता हेतु आवेदन प्रारूप

(Healthcare)

(स्वास्थ्य देखभाल)



Koshika

foundation

Building block of life.

APPLICATION No. :

आवेदन संख्या :

A/0419/0003

APPLICATION DATE :

आवेदन तिथि

11/04/19

NAME of APPLICANT :

आवेदक का नाम

Rameshwar

AGE-YEARS आयु-वर्ष

SEX लिंग

65

M

FATHER'S/SPOUSE'S NAME :

पिता/कटुम्ब का नाम

Sugdu Ram

PRESENT RESIDENCE ADDRESS वर्तमान अस्थायी पता

Village - Buh ka Hara, T.B. - Tizara.

Dist. - Alwar, Rajasthan

PERMANENT RESIDENCE ADDRESS : स्थाई अस्थायी पता

as above


 Pre-op. Post-op.
 0003 Rameshwar

OCCUPATION :

व्यवसाय

Farmer

MARRIED (विवाहित) / UNMARRIED (अविवाहित)

TOTAL ANNUAL INCOME :

कुल वार्षिक आय

80000

(Attach Proof of Income)

(आय का साक्ष्य संलग्न)

NA

PAN No. स्थाई करदाता संख्या

NA

ARE YOU AN INCOME TAX ASSESSEE (Tick whichever is applicable):

क्या आप आय कर दाता हैं (जो मान्य हो उस पर सही का चिह्न लगाएं)

Yes / No

हां / नहीं

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
(i)	Kushe Ram	98	M	son
(ii)	Ude Ram	90	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 छाया प्रति संलग्न करें)	EWS Certificate (Attach Certificate Copy) आय आय वर्ग प्रमाण पत्र (प्रमाण पत्र की छाया प्रति संलग्न करें)	Ration Card (Attach Copy) उपभोग्य कार्ड (प्रमाण पत्र की छाया प्रति संलग्न करें)	Any Other Basis/Proof अन्य कोई साक्ष्य
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"PURPOSE" for REQUESTING ASSISTANCE:

सहायता हेतु किये गये विनती का उद्देश्य:

Sr. No. क्रम संख्या	Medical Reports/Prescriptions Attached अस्पताल/डॉक्टर से जारी की गई प्रतिवेदन सुची संलग्न
1.	Diagnosis — RF-IMSC LE-IMSC
2.	Surgery — RF-SICS + JOL

ASSISTANCE BEING AVAILED for SAME "PURPOSE" from OTHER SOURCES

इस उद्देश्य के हेतु कोई अन्य सहायता किसी अन्य स्रोत से लिया गया हो?

Sr. No. क्रम संख्या	NAME of OTHER SOURCE अन्य स्रोत का नाम	AMOUNT of ASSISTANCE BEING AVAILED लौ गई सहायता राशि
1.	SCPM	

DECLARATION by APPLICANT: **जयदेव इन्द्र सोपान पात्र:**

- 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 & ongo-
 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
 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 compa-
 for which this assistance is requested.
- 1) मैं यहाँ पर बताना हूँ कि इस प्रारूप में दिये गये सभी विवरण सही जानकारी के अनुसार सत्य एवं सही हैं। यदि कोई विवरण पूर्व कथन अथवा प्राप्त ज्ञान है तो मेरी सहमति निम्न
 2) मेरी द्वारा जो सहायता प्राप्त "कठिनाई का निराकरण", से रही का रही है, उसका उपयोग उसी उद्देश्य की पूर्ति के लिये किया जाएगा, जो इस प्रारूप में बताया गया है।
 3) मैं यहाँ पर बताना हूँ कि मैं इस सहायता से प्राप्त लाभ का उपयोग किसी अन्य स्रोत/रोजगार/बीमा कम्पनी से या किसी अन्य स्रोत से नहीं करूँगा।

AGREEMENT by APPLICANT (संलग्नक संख्या ५०००)

- 1) By affixing my signature or thumb impression on this Form, I (Applicant) hereby agree & authorise Koshika Foundation and it's Trustees to use/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

आवेदक के हस्ताक्षर या अंगूठे का निशान

AGREEMENT by HOSPITAL (हॉस्पिटल से सहमति)

By affixing hereunder, signature of our Authorized 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 ACCEPTANCE

स्वीकृती के लिए संस्तुति

Date of Surgery

अनुसंधान की गहरी समझ

10

Dr. Dharm Singh

(Name of the Party/Person/Institution)

आपका नाम : _____

~~Reg. No. 028054~~

(Name, Designation & Stamp of Authorised Signatory)

on **Administrative**

આ વડાકે કહ્યું કે જોઈએ સંસ્કૃતિ, Alwar

FOR INTERNAL USE OF KOSHIKA FOUNDATION

अन्तरिक रूपरेखा

SIGNATURE of TRUSTEE 1

न्यासी इत्यादि ।

SIGNATURE of TRUSTEE 2

स्वामी महाराज २