

21/09/0666

# APPLICATION FORM FOR ASSISTANCE

सहायता हेतु आवेदन प्रारूप

(Healthcare)

(स्वास्थ्य देखभाल)

**Koshika**  
foundation  
Building block of life.

APPLICATION No. :

आवेदन संख्या :

A/0919/0546

APPLICATION DATE :

आवेदन तिथि

16/09/19

NAME of APPLICANT :

आवेदक का नाम

Nanna

AGE-YEARS आयु-वर्ष

SEX लिंग

52

M

FATHER'S/SPOUSE'S NAME :

पिता/कटुम्ब का नाम

Hansraj

PRESENT RESIDENCE ADDRESS वर्तमान आवासीय पता

Village → Mandhar, Teh. → Rishraengach Bazar

Dist. → Alwar, Rajasthan

PERMANENT RESIDENCE ADDRESS : स्थायी आवासीय पता

as above



Preop.

Postop.

0546

Nanna

OCCUPATION :

व्यवसाय

labourer

MARRIED (विवाहित) / UNMARRIED (अविवाहित)

TOTAL ANNUAL INCOME :

कुल वार्षिक आय

55,000

(Attach Proof of Income)

(आय का साक्ष्य संलग्न)

NA

PAN No. स्थायी खाता 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 निशान लगाएं)

Yes / No

हां / नहीं

FAMILY DETAILS परिवार विवरण

| Sr. No.<br>क्रम संख्या | Name of Family Member<br>परिवार के सदस्यों का नाम | Age (Years)<br>उम्र (वर्ष) | Gender<br>लिंग | Relation with Applicant<br>आवेदक के साथ सम्बंध |
|------------------------|---------------------------------------------------|----------------------------|----------------|------------------------------------------------|
| 1                      | Sumit                                             | 22                         | M              | Son                                            |
| 2                      | Amal                                              | 18                         | M              | Son                                            |

BASIS for REQUESTING ASSISTANCE (Tick whichever is applicable)

सहायता के लिये विधि आधार

|                                                                                                             |                                                                                                                     |                                                                                           |                                              |
|-------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------|----------------------------------------------|
| BPL Card<br>(Attach Card Copy)<br>गरीबी रेखा के नीचे प्रमाण पत्र<br>(प्रमाण पत्र की छाया प्रति संलग्न करें) | EWS Certificate<br>(Attach Certificate Copy)<br>अल्प आय वर्ग प्रमाण पत्र<br>(प्रमाण पत्र की छाया प्रति संलग्न करें) | Ration Card<br>(Attach Copy)<br>उपभोक्ता कार्ड<br>(प्रमाण पत्र की छाया प्रति संलग्न करें) | Any Other<br>Basis/Proof<br>अन्य कोई साक्ष्य |
|-------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------|----------------------------------------------|

"PURPOSE" for REQUESTING ASSISTANCE:

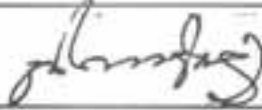
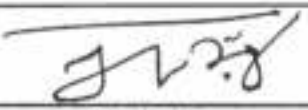
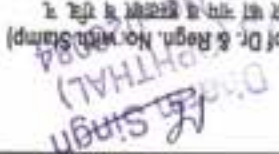
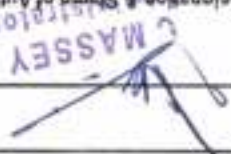
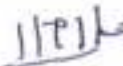
सहायता हेतु किये गये निम्नी का उद्देश्य:

| Sr. No.<br>क्रम संख्या | Medical Reports/Prescriptions Attached<br>अस्पताल/डॉक्टर से जारी की गई प्रतिवेदन सूची संलग्न |
|------------------------|----------------------------------------------------------------------------------------------|
| 1                      | Diagnosis → HF - MSC<br>IF - MSC                                                             |
| 2                      | Surgery → IF - SICU + IOL                                                                    |

ASSISTANCE BEING AVAILED for SAME "PURPOSE" from OTHER SOURCES

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

| Sr. No.<br>क्रम संख्या | NAME of OTHER SOURCE<br>अन्य स्रोत का नाम | AMOUNT of ASSISTANCE BEING AVAILED<br>ली गई सहायता राशी |
|------------------------|-------------------------------------------|---------------------------------------------------------|
| 1                      | SCH                                       |                                                         |

|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |  |                                                                                                                                                                |  |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|----------------------------------------------------------------------------------------------------------------------------------------------------------------|--|
| SIGNATURE of TRUSTEE 1<br>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |  | SIGNATURE of TRUSTEE 2<br>                                                     |  |
| FOR INTERNAL USE OF KOSHKA FOUNDATION                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |  |                                                                                                                                                                |  |
| Date of Surgery<br>17/9/19                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |  | (Name of Dr. & Regn. No. with Stamp)<br>                                     |  |
| Date of Surgery<br>17/9/19                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |  | (Name, Designation & Stamp of Authorized Signatory on behalf of Hospital)<br> |  |
| RECOMMENDED FOR ACCEPTANCE                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |  |                                                                                                                                                                |  |
| By affixing hereunder, signature of our Authorized Signatory for recommending this case/patient for financial assistance from Koshka Foundation, we assume sole & complete responsibility of the treatment & its outcome & safety of the patient, and Koshka Foundation will have no role or responsibility in the matter.<br>(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 Koshka Foundation, to the extent that such assistance is granted by Koshka Foundation. If the requested assistance is not granted by Koshka 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 Koshka 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 Koshka Foundation. Hence, the Hospital will assume sole & complete responsibility of the treatment & its outcome & safety of the patient, and Koshka Foundation will have no role or responsibility in the matter.<br>(1) we for & it confirm that we are not availing any financial assistance from any other source, for the same patient/case, as we are requesting to get from Koshka Foundation, to the extent that such assistance is granted by Koshka Foundation. If the requested assistance is not granted by Koshka 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 Koshka 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 Koshka Foundation. Hence, the Hospital will assume sole & complete responsibility of the treatment & its outcome & safety of the patient, and Koshka Foundation will have no role or responsibility in the matter. |  |                                                                                                                                                                |  |
| AGREEMENT BY HOSPITAL (KOSHKA FOUN.)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |  |                                                                                                                                                                |  |
| APPLICANT'S SIGNATURE OR LEFT THUMB IMPRESSION :<br>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                                |  |
| 1) By affixing my signature or thumb impression on this Form, I (Applicant) hereby agree & authorize Koshka Foundation and its Trustees to use/publish/post-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 Koshka Foundation and/or disseminating information about its activities/achievements. Such use of my photo & details can be made by Koshka Foundation before or after my treatment or fulfillment of the "purpose" for which assistance is being requested.<br>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 Koshka Foundation, and their decision is the final and acceptable to me.<br>3) I (Applicant) agree that I will not receive any financial assistance from any other source, for the same patient/case, as we are requesting to get from Koshka Foundation, to the extent that such assistance is granted by Koshka Foundation. If the requested assistance is not granted by Koshka 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 Koshka 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 Koshka Foundation. Hence, the Hospital will assume sole & complete responsibility of the treatment & its outcome & safety of the patient, and Koshka Foundation will have no role or responsibility in the matter.                                                                                                                                                                                                                                                                                                                                                                              |  |                                                                                                                                                                |  |
| AGREEMENT BY APPLICANT (KOSHKA FOUN.)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |  |                                                                                                                                                                |  |
| 1) I (Applicant) hereby agree & authorize Koshka Foundation and its Trustees to use/publish/post-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 Koshka Foundation and/or disseminating information about its activities/achievements. Such use of my photo & details can be made by Koshka Foundation before or after my treatment or fulfillment of the "purpose" for which assistance is being requested.<br>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 Koshka Foundation, and their decision is the final and acceptable to me.<br>3) I (Applicant) agree that I will not receive any financial assistance from any other source, for the same patient/case, as we are requesting to get from Koshka Foundation, to the extent that such assistance is granted by Koshka Foundation. If the requested assistance is not granted by Koshka 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 Koshka 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 Koshka Foundation. Hence, the Hospital will assume sole & complete responsibility of the treatment & its outcome & safety of the patient, and Koshka Foundation will have no role or responsibility in the matter.                                                                                                                                                                                                                                                                                                                                                                                                                                         |  |                                                                                                                                                                |  |
| DECLARATION BY APPLICANT: KOSHKA FOUN. (KOSHKA FOUN.)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |  |                                                                                                                                                                |  |
| 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.<br>2) I solemnly confirm that assistance, if received from Koshka Foundation, will be used only for the "purpose", as stated in this Form, for which such assistance was requested by me.<br>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.<br>4) I (Applicant) agree that I will not receive any financial assistance from any other source, for the same patient/case, as we are requesting to get from Koshka Foundation, to the extent that such assistance is granted by Koshka Foundation. If the requested assistance is not granted by Koshka 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 Koshka 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 Koshka Foundation. Hence, the Hospital will assume sole & complete responsibility of the treatment & its outcome & safety of the patient, and Koshka Foundation will have no role or responsibility in the matter.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |  |                                                                                                                                                                |  |