

URN = C-20-01-0463

APPLICATION FORM FOR ASSISTANCE

सहायता हेतु आवेदन प्रारूप

(Healthcare)

(स्वास्थ्य देखभाल)



APPLICATION No. आवेदन संख्या: **U/012011035**

APPLICATION DATE: 13-01-20
आवेदन तिथि

NAME of APPLICANT आवेदक का नाम: **Luuddi**

AGE-YEARS आयु-वर्ष: **54** SEX लिंग: **F**

FATHER'S/SPOUSE'S NAME पिता/सहस्रवधु का नाम: **Rajveer Singh**
PRESENT RESIDENCE ADDRESS वर्तमान अवासीय पता: **meemgaon, Raya**
DIST: **mathura, U.P. 281204**
PERMANENT RESIDENCE ADDRESS स्थाई अवासीय पता: **same as Above**



OCCUPATION: व्यवसाय: **Home maker**

MARRIED (विवाहित) / UNMARRIED (अविवाहित)

TOTAL ANNUAL INCOME: कुल वार्षिक आय: **210000**

(Attach Proof of Income) (आय का साक्ष्य संलग्न): **NA**

PAN No.: स्वयं छात्रा संख्या

ARE YOU AN INCOME TAX ASSESSEE (Tick whichever is applicable): क्या आप आय कर दाता हैं (जो बाल्य हो उस पर सही का निशान लगाये): Yes / No हाँ / नहीं हाँ

| 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 | Lavith | 48 | M | Husband |
| 2 | Mohit | 20 | M | SON |
| 3 | Rohit | 18 | M | SON |

BASIS for REQUESTING ASSISTANCE (Tick whichever is applicable) सहायता के लिये विवृति आधार

| | | | |
|--|--|---|--|
| BPL Card (Attach Card Copy) गरीबी रेषा के नीचे प्रमाण पत्र (प्रमाण पत्र की छाया प्रति संलग्न करें) | EWS Certificate (Attach Certificate Copy) अन्य आय को प्रमाण पत्र (प्रमाण पत्र की छाया प्रति संलग्न करें) | Ration Card (Attach Copy) उपभोगिका कार्ड (उपभोग पत्र की छाया प्रति संलग्न करें) | Any Other Basis/Proof अन्य कोई साक्ष्य |
|--|--|---|--|

"PURPOSE" for REQUESTING ASSISTANCE सहायता हेतु किये गये विवृति का उद्देश्य:

| Sr. No. क्रम संख्या | Medical Reports/Prescriptions Attached (अस्पताल/डॉक्टर से जारी की गई प्रमाणपत्र सूची संलग्न) |
|---------------------|--|
| | RE - P.S.C |
| | LE - IMS C |
| | Surgey = (IE) SACS FJOL |

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. क्रम संख्या | NAME of OTHER SOURCE अन्य स्रोत का नाम | AMOUNT of ASSISTANCE BEING AVAILED (की गई सहायता राशी) |
|---------------------|--|--|
| 1 | SCEH | |

DECLARATION by APPLICANT (अर्शक द्वारा घोषणा पत्र)

- 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.
 - 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.
 - 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 यथाथरत कतल हूँ कि इस ढरररत में रिटेर गये सभरर विवरण सरीर सतुकररर के ढररुसरत सतत एवं सरीर है। ढररि कुररर विवरण एवं कथन असतत ढररत ढररत हूँ तूँ ढररि सहायतल ररररत करर सतुकररर है।
 2) ढररि हूँ ढररि सहायतल ढरररर "कुररशररक ढरररररररररत", ढररि कररर कररर है, उतलकरर उढररर उढररर कररर रुरररर के ररररर कररररर। अं इस ढरररत में ढररत ढररत है।
 3) ढररि रुरररर कतल हूँ कि रररर सहायतल हूँ ढररर ढरररररर कररर है, उतल ररररर कररर उढररररर कुररररर कुररररर ढररr

AGREEMENT by APPLICANT (अर्शक द्वारा सतुकर)

- By affixing my signature or thumb impression on this Form, I (Applicant) hereby agree & authorize Koshika Foundation and its Trustees to use/publish/print/photograph/produce 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 its 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.
 - 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.
- 1) इस ढरररत में ढररr

APPLICANT'S SIGNATURE OR LEFT THUMB IMPRESSION :

अर्शक के हतलकररr

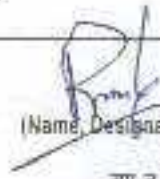


AGREEMENT by HOSPITAL (हस्पताल द्वारा सतुकर)

- 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:
- 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.
 - 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.
- इससे अधररररर, हतलकरररr
- यड कि न तूँ ढरररr
 - "कुररशररक ढरररr

RECOMMENDED FOR ACCEPTANCE

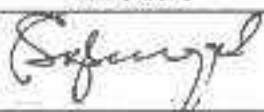
Dr. Ashwini Kumar
 M.B.B.S., M.S. Ophthalmology
 Reg. No - 66028
 Time _____ Date _____
 (Name of Dr. & Regn. No. with Stamp)
 हतलकरररr


 (Name, Designation & Stamp of Authorized Signatory on behalf of Hospital)
 ढररr



FOR INTERNAL USE of KOSHIKA FOUNDATION आन्तररररर उढररररर हूँ

SIGNATURE of TRUSTEE 1
 ढररररररररररररर



SIGNATURE of TRUSTEE 2
 ढररररररररररररर

