APPLICATION FORM FOR ASSISTANCE
सहायता हेतु आवेदन प्रारूप (Healthcare)

Koshika foundation
Building blocks of life

APPLICATION No. आवेदन संख्या: K/0225/1894

APPLICATION DATE आवेदन तिथि: 11/2/25

NAME of APPLICANT आवेदक का नाम: MINA SAHA

AGE-YEARS आयु-वर्ष: 69

SEX लिंग: F

FATHER'S/SPOUSE'S NAME पिता/पति का नाम: MAHADEB SAHA

PRESENT RESIDENCE ADDRESS वर्तमान आवासीय पता:
K.C.GM STREET NO.6 HELGHORIA
NORTH 24 PARGONA 700156
WEST BENGAL

PERMANENT RESIDENCE ADDRESS स्थाई आवासीय पता:
— AS ABOVE —

OCCUPATION व्यवसाय: HOME MAKER

MARRIED (विवाहित) / UNMARRIED (अविवाहित): MARRIED

TOTAL ANNUAL INCOME कुल वार्षिक आय: ₹ 6000 X 12 = 72000 (Attach Proof of Income आय का प्रमाण संलग्न)

PAN No. पैन कार्ड संख्या:

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

FAMILY DETAILS परिवार विवरण

Sr. No. क्रम संख्या	Name of Family Member परिवार के सदस्यों का नाम	Age (Years) आयु (वर्ष)	Gender लिंग	Relation with Applicant आवेदक से संबंध
	MINA SAHA	69	F	SELF
	KALIPADA SAHA	82	M	HUSBAND
	GOUTAM SAHA	50	M	SON
	BIPLAB SAHA	46	M	SON
	MITHU SAHA	43	F	DAUGHTER

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

BPL Card (Attach Card Copy) गरीबी रेखा के नीचे प्रमाण पत्र (प्रमाण पत्र की छाया प्रति संलग्न करें)	EWS Certificate (Attach Certificate Copy) आर्थ आय वर्ग प्रमाण पत्र (प्रमाण पत्र की छाया प्रति संलग्न करें)	Ration Card (Attach Copy) राशन कार्ड (छाया प्रति को आवेदन पत्र संलग्न करें)	Any Other Basis/Proof अन्य कोई आधार

"PURPOSE" for REQUESTING ASSISTANCE
सहायता हेतु किये गए विशेष का उद्देश्य

Sr. No. क्रम संख्या	Medical Reports/Prescriptions Attached आवश्यक/डॉक्टर से जारी की गई प्रतिलिपि संलग्न
1.	DIAGNOSIS — CATARACT — RE
2.	SURGERY — RE (SICS+IOL)

ASSISTANCE BEING AVAILED for SAME "PURPOSE" from OTHER SOURCES
इस उद्देश्य के लिए 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 ली गई सहायता राशि

DECLARATION by APPLICANT : आवेदक द्वारा घोषणा पत्र

1) I hereby confirm that all details in this Form are true to the best of my knowledge. Any false [illegible] 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 [illegible]/employer/insurance company, of the amount for which this assistance is requested.

1) [illegible]

2) [illegible] "कोशिका फाउंडेशन" [illegible]

3) [illegible]

AGREEMENT by APPLICANT : आवेदक द्वारा करार

1) By affixing my signature or thumb impression on this Form, I (Applicant) hereby agree & authorise Koshika Foundation and its 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 its activities/achievements. Such use of my photo & details can be made by Koshika Foundation before or after my treatment or fulfilment 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 [illegible], for which such assistance is requested/granted, will not automatically entitle me for receiving or continuing the said assistance. The decision [illegible] continuing the assistance will rest solely with the Trustees of Koshika Foundation, and their decision in this regard will be final and [illegible].

1) [illegible] "कोशिका" [illegible]

2) [illegible] "कोशिका" [illegible]

APPLICANT'S SIGNATURE OR LEFT THUMB IMPRESSION :
आवेदक के हस्ताक्षर या अंगूठे का निशान

AGREEMENT by HOSPITAL : हॉस्पिटल द्वारा करार

By affixing hereunder, signature of our Authorised Signatory for recommending the case/patient to [illegible] 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 [illegible] from any other NGO or any other source.

2) The assistance from Koshika Foundation is only financial in nature. The choice of the [illegible] by the Hospital on the patient is based on the arrangement between the patient & the hospital, and [illegible] Koshika Foundation. Hence, the Hospital will [illegible] sole & complete responsibility of the treatment & its outcome & safety of the patient, and Koshika Foundation will have no role or responsibility in the matter.

[illegible] "कोशिका फाउंडेशन" [illegible]

1) [illegible] "कोशिका फाउंडेशन" [illegible] "कोशिका फाउंडेशन" [illegible]

2) "कोशिका फाउंडेशन" [illegible] "कोशिका फाउंडेशन" [illegible] "कोशिका" [illegible]

RECOMMENDED FOR ACCEPTANCE
स्वीकृति के लिए संस्तुति

Date of Surgery ऑपरेशन की तारीख	Name of Dr. & Regn. No. with Stamp डॉक्टर का नाम व रजिस्ट्रेशन न. (मुहर)	Name, Designation & Stamp of Authorised Signatory on behalf of Hospital हॉस्पिटल की ओर से अधिकृत अधिकारी
11/02/25		

FOR INTERNAL USE of KOSHIKA FOUNDATION : आंतरिक उपयोग हेतु

SIGNATURE of TRUSTEE 1 ट्रस्टी हस्ताक्षर 1	SIGNATURE of TRUSTEE 2 ट्रस्टी हस्ताक्षर 2

16.03.2022