## APPLICATION FORM FOR ASSISTANCE

**Date:** 11/6/2006

### NAME OF APPLICANT:
Tanya

### FATHER/HUSBAND'S NAME:
Buddha Ram

### OCCUPATION:
Farmer

### TOTAL ANNUAL INCOME:
25000

### ARE YOU AN INCOME TAX ASSESSSEE (Tick whichever is applicable):
Yes

### FAMILY DETAILS:

<table>
<thead>
<tr>
<th>Sr. No.</th>
<th>Name of Family Member</th>
<th>Age (Years)</th>
<th>Gender</th>
<th>Relation with Applicant</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Hawkya</td>
<td>68</td>
<td>P</td>
<td></td>
</tr>
<tr>
<td>2</td>
<td>Veer Vraj</td>
<td>55</td>
<td>M</td>
<td></td>
</tr>
<tr>
<td>3</td>
<td>Naresh Darji</td>
<td>80</td>
<td>M</td>
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### BASIS for REQUESTING ASSISTANCE (Tick whichever is applicable):

- **BPL Card**
- **EWS Certificate**
- **Ration Card**

### "PURPOSE" for REQUESTING ASSISTANCE:
- Diagnosis (1)
- Surgery a SICB + 101 (1)

### ASSISTANCE BEING AVAILED for SAME "PURPOSE" from OTHER SOURCES

<table>
<thead>
<tr>
<th>Sr. No.</th>
<th>NAME OF OTHER SOURCE</th>
<th>AMOUNT of ASSISTANCE BEING AVAILED</th>
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<tr>
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DECLARATION by APPLICANT: 

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 null and void for rejection/cancellation.

2) I hereby confirm that assistance, if received from Koshika Foundation, will be used entirely for the "purpose", as stated in this Form, for which such assistance is requested.

3) I hereby confirm that I have not & will not in future, avail of reimbursement, in part or in full, from any other source/employee/insurance company, of the amounts for which this assistance is requested.

1) I am aware that I am liable to return all the 

2) I am aware that I am liable to return all the 

3) I am aware that I am liable to return all the 

AGREEMENT by APPLICANT: 

1) By affixing my signature or thumb impression on this Form, I (Applicant) hereby agree & authorise Koshika Foundation and its Trustees to use/publish/print reproduce my name, address, photo & details of the "purpose", for which such assistance is requested/granted, through any medium, including but not limited to virtual, 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.

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: 

AGREEMENT by HOSPITAL: 

By affixing her/his signature of our Authorized Signatory for recommending this patient for financial assistance from Koshika Foundation, we (Hospital) hereby affirm & accept the following:

1) That we neither are presently nor will be 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 extends to 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/undertaken 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 outcome & safety of the patient, and Koshika Foundation will have no role/responsibility in the matter.

RECOMMENDED For (Tick Acceptance or Rejection as applicable) 

Date of Surgery

Signature of Trustee 1

Signature of Trustee 2

FOR INTERNAL USE OF KOSHICA FOUNDATION

Sanctioned

Recommended

Accepted

Rejected