



GRANT APPLICATION

This application is CONFIDENTIAL but must be completed for you to be considered for assistance from Kati's Hope Foundation. Please complete all four pages and make sure you sign the release form before mailing it back to us.

Name

Address

Phone Number & Best Time to Call

Referred By

MEDICAL INFORMATION

Please attach a copy of your pathology report for verification purposes.

Physician's Name

Phone

Medical Facility

Nurse/Social Worker Name

Phone

Medical Facility

MEEZ-o-THEE-lee-o-ma: A cancer closely associated to a history of asbestos exposure
PO Box 24693 • Cleveland, Ohio 44124-0693 • Phone/Fax: 216-378-0008 • katishope.com

Kati's Hope is a 501(c)(3) corporation and all donations are tax deductible as allowed by law.

Kati's Hope

Research,
Education
& Support



FOUNDATION FOR
MESOTHELIOMA

PERSONAL INFORMATION

Marital Status (Check one): Single Married Widowed
 Partnered Separated Divorced

Date of Birth _____

How many persons are living in your household including yourself? _____

Do you rent or own your home? _____

Are you currently employed? _____

Are you receiving public or private assistance? If yes, amount? _____

Do you have health insurance? If yes, what type? _____

After taxes household income per year for all persons in household _____

Are you currently or have you in the past been given grants or aid from other foundations? If yes, please list name of foundation and the amount of the grant received you received. _____

NEEDS ASSESSMENT

What items below do you need help with?

Housing – rent or mortgage payment

Transportation costs (needed for hospital/doctor visits)

Utility or phone bill payments

Groceries

Medications

Treatment costs

Other (Please explain) _____

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RELEASE FORM

I understand and agree to the following:

- 1) All information in the three page grant application submitted to Kati's Hope Foundation will remain confidential.**
- 2) My physicians, nurses/social workers and medical facilities can provide information to Kati's Hope Foundation relating to any treatment or care for mesothelioma and other related health problems if necessary. The Foundation agrees all medical information submitted is confidential.**
- 3) No promises or assurances were made to me by any representative of Kati's Hope Foundation regarding the assistance I am requesting of them.**
- 4) There is a limit to the amount of assistance Kati's Hope Foundation can provide.**
- 5) Kati's Hope Foundation can publicize its service. However, my name and address will be blacked out on any printed matter, unless I advise otherwise.**

Signed by applicant

Date

Witness

Date

Please mail this form to:

Kati's Hope Foundation, P O Box 24693, Cleveland, OH 44124-0693

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