THE KALEIDOCSOPE OF HOPE OVARIAN CANCER FOUNDATION

P.O. BOX 1124
MADISON, NJ 07940
P: 973-644-0500 info@kohnj.org

Community Grant Application

Community Grants are available to New Jersey Residents Only

Name Of Applicant: _____ Age: _____ DOB: _____

Number and ages of children or siblings: _____

Spouse/Parents Name (if child):_____

Address:_____

E-mail address:_____ How Did You Hear About us: _____

Phone #_____ Cell #_____

Diagnosis & Prognosis & Treatment Status (please include dates):

_____

_____

Other Charitable Organizations That Have Provided Assistance:

_____

_____

Assistance Requested and Reasons Why Needed:

_____

_____

Doctor Contact Info: _____

I hereby give consent to Kaleidoscope of Hope to contact my physician for patient verification Yes_____ No_____

I hereby stipulate that my current yearly financial situation is the following. Please Select one.

Below $50,000.00 _____ $50,0000-$100,000.00 _____ Over $100,000.00 _____

This document contains information which will be kept confidential. The purpose of the request is so the Foundation can decide on assistance. Sometimes it may be necessary to request additional information. The KOH Foundation thanks you for taking the time to fill out this form. If you have any questions, please call the Foundation at the number stated above.