"CLOT LINE"

(334) 478-7822

Assistance Request Form

Name of Applicant: **(Parent/Guardian name in case of minor)**		Bleeding Disorder	D.O.B / /
Age	Marital Status: ☐ Single ☐ Married ☐ Separated ☐ Divorced		Gender: ☐ M ☐ F
Address _____ Street Apt # City State Zip		_____ County	How long at this address?
Home #		Cell #	Fax #
Work #		Email	
Employer	Occupation	Gross Monthly Income	Hemophilia Treatment Center & Date of Last Visit:

Employment History (Please list employers and dates of employment for last 2 Years):

Other Adult in Home		Bleeding Disorder	D.O.B / /
Age	Marital Status: ☐ Single ☐ Married ☐ Separated ☐ Divorced		Gender: ☐ M ☐ F
Home #		Cell #	Fax #
Work #		Email	
Employer	Occupation	Gross Monthly Income	

Other Members in Household (List additional members on a separate sheet and attach.)

Name	Bleeding Disorder/Severity	D.O.B.	Relationship	Factor Used

Gross Monthly Income			Monthly Expenses	
Employment	$		Rent/Mortgage	$
Unemployment	$		Electric	$
Worker's Comp	$		Water	$
Pension	$		Propane	$
Child Support	$		Home Phone	$
Social Security	$		Food	$
SSI	$		Car Payment	$
SSD	$		Car Insurance	$
Food Stamps	$		Credit Cards (Total)	$
Bank Accounts (Total Checking & Savings)	$		Cell Phone (How Many) _____	$
Other (specify)	$		Cable/Satellite Internet	$
Other (specify)	$		Other (specify)	$
Total	$		Total	$

Type of Assistance Requested: ☐ Medical Bill/Co-Pay ☐ Housing/Rent ☐ Utilities ☐ Auto Repair/Gas ☐ Other (Please Specify) _____	
Total Amount of Bill or Payment: $	Amount Requested: $
All determinations will be evaluated on a case-by-case basis based on availability of funds and circumstances.	
Describe the nature of the emergency:	
Describe how assistance will help handle current problem:	
How has the applicant tried to handle the problem? Mention other assistance programs (CRS If Co-Pay, Medical Bills or Insurance Premium), Local Churches, Payment Arrangements w/creditor, HFA, etc.)	
Comments/Recommendations:	
Payment to be issued to: (Should be landlord, mortgage or utility company or other qualified vendor). Please include a copy of the mortgage coupon, rent receipt, or current utility bill.	
Vendor Name:	Account Name:
Account Number:	Phone Number:
Payment Address:	
******All sections must be filled out and supporting document(s) must be attached prior to processing.******	
Release of Information/Applicant Attestation: I certify that the information I have provided in the above is true and correct. I consent to the release of pertinent information contained in this application to Hemophilia and Bleeding Disorders of Alabama, Inc., other social service agencies which distribute emergency financial assistance, the company or individual to receive funds as necessary to complete the services to my household, or to provide statistics on emergency assistance, or as a guard against duplicate assistance. I also consent to release of patient information to the federal government and those utility companies which require documentation of recipient's funds. **Signature: _____ Date: _____**	

----------HBDA Office Only----------

List all dates of prior emergency assistance from this fund in last 12 months:

1.	**2.**	**3.**
HBDA Approval Signatures/Date:	**1.**	**2.**
Date check issued:	**Check #**	**Issued to:**

Hemophilia and Bleeding Disorders of Alabama, Inc.
4031 US Highway 231
Wetumpka, AL 36093
(334) 478-7822