**Financial Assistance Program Application Form**

***\*Please Print\****

1. **Applicant\* Information**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Name: | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | |
|  | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | |
| Address: |
|  | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |  | \_\_\_\_\_\_\_\_\_\_\_ |  | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| City: | State: | Zip: |
|  | | | | | |
| Phone 1: | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | Email: | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | |
|  | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | |
| Phone 2: |

1. **Referral Information**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Who referred you to MHA? | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | |
|  | |  | |  |
| May we contact this person? (Y/N) | | \_\_\_\_\_\_\_\_\_\_ | Phone Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | |
|  | |  | |  |
| Are you a patient at an HTC? (Y/N) | | \_\_\_\_\_\_\_\_\_\_ | Which HTC? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | |
|  | | | | |
| If No, where do you receive medical care for your bleeding disorder? | | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | |

1. **Request for Assistance**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Amount Requested: | \_\_\_\_\_\_\_\_\_\_ | | Date Needed By: | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
|  |  | |  |  |
| Reason for this Request: | | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | |
|  |  | |  |  |
| \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | |
|  |  | |  |  |
| \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | |
|  |  | |  |  |
| \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | |

1. **MHA requires applicants first seek assistance from two agencies before applying to MHA.** *Please identify these agencies below:*

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Name: | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | Phone: | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | Status: | \_\_\_\_\_\_\_\_\_\_\_\_ |
|  |  |  |  |  |  |
| Name: | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | Phone: | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | Status: | \_\_\_\_\_\_\_\_\_\_\_\_ |

1. **Creditor – the business/individual to whom MHA should send the check:**

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| Name: | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | |
|  | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | |
| Address: |
|  | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |  | \_\_\_\_\_\_\_\_\_\_\_ | |  | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| City: | State: | Zip: |
|  | | | | | | |
| Phone 1: | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | Account Number: | | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | |

***Please Note:*** *Parents of adult children with a bleeding disorder or spouses of a person with a bleeding disorder may NOT apply on behalf of their spouse or adult child unless they provide an explanation of disability that prevents the adult with a bleeding disorder from applying on their own behalf.*

1. **Please list ALL members of the household (including non-family members)**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Name** | **Age** | **Does this person have a bleeding disorder?** | **Types of bleeding disorder** | **Relationship to person with bleeding disorder\*** |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |

\*Types of relationships can include: self, spouse, parent, sibling, roommate, etc.

1. **Employment Information**

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| Applicant’s Employer: | | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | |
|  | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | |
| Address: |
|  | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | |  | \_\_\_\_\_\_\_\_\_\_\_ |  | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| City: | State: | Zip: |
|  | | | | | | |
| Phone 1: | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | |

|  |  |  |  |
| --- | --- | --- | --- |
| List of employers of other household members: | | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | |
|  | | | |
| \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | |
|  | | |  |
| **TOTAL Monthly Household Income**: | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | |

(List **ALL** income from **ALL** other members of the household. Sources of income can include: employment wages, unemployment, SSI/SSDI/SSD, Food Stamps, spousal/child support, assistance from relatives, etc. MHA reserves the right to request a copy of your most recent tax return for verification of income)

1. **Past Assistance**

Have you applied for assistance from MHA in the past? (Y/N): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

If yes, please give month/year: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

* ***PLEASE NOTE:*** Midwest Hemophilia Association (MHA) grants are never made directly to individuals, only to creditors that can be verified by MHA. Because of its limited resources, MHA limits assistance to $500 per household. MHA assistance is limited to once every two years.
* Personal Information will not be used or disclosed for purposes other than those for which it was collected. At no time is personal information shared with any individual, company, or organization outside of MHA.\*\*

***Submittal of Bill****:* All pages of the bill in question must be submitted to MHA before the application for financial assistance can be reviewed. Please check the option below that applies:

\_\_\_\_\_ I am attaching complete documentation of the bill to this application.

\_\_\_\_\_ I need to send complete documentation of the bill separately. Explain:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

SIGNATURE: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DATE: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Return this form, along with a copy of the bill for which you are requesting assistance, to:

Midwest Hemophilia Association

1471 W. South Street

Suite F

Ozark, MO 65721

QUESTIONS? CALL MHA at 816-479-5900