**FINANCIAL ASSISTANCE PROGRAM APPLICATION**

**\*Click on the line to begin typing. Lines will automatically grow as needed. Otherwise, please print clearly. \***

1. **Applicant Information**

|  |  |  |  |
| --- | --- | --- | --- |
| Applicant |  | Address |  |

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| City |  | State |  | Zip |  | Phone |  |

|  |  |  |  |
| --- | --- | --- | --- |
| Email |  | Applicant DOB |  |

**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 child or spouse unless they provide an explanation of disability that prevents the adult with a bleeding disorder from applying on their own behalf.*

|  |  |
| --- | --- |
| Explanation  |  |

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

 \*TYPES OF RELATIONSHIPS CAN INCLUDE: self, spouse, son, daughter, parent, sibling, roommate, etc.

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| NAME-include last name if different than applicant | Date of Birth | Does this person have a bleeding disorder? | Types of bleeding disorder | Relationship to person with bleeding disorder\* |
|  |  |  |  |  |
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|  |  |  |  |  |

1. **Referral Information**

|  |  |  |  |
| --- | --- | --- | --- |
| Who referred you to MHA? |  | May we contact them? (Y/N) |  |
| Referrer’s Phone:  |  |  |  |

|  |  |
| --- | --- |
| Name of Hemophilia Treatment Center where patient(s) is seen:  |  |

|  |  |
| --- | --- |
| If patient(s) are NOT seen at an HTC, where is medical care received for their bleeding disorder?  |  |

1. **Request for Assistance**

|  |  |  |  |
| --- | --- | --- | --- |
| Amount Requested  |  | Date Needed By |  |

Describe the reason/situation for the request in as much detail as possible: (Use the back or add more pages if needed)

|  |
| --- |
|  |

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1. **MHA requires applicants to first seek assistance from two agencies before applying for this program.**

Please identify these agencies (Example: church, local charity, HFA, etc.)

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Agency Name 1 |  | Phone |  | Status |  |

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Agency Name 2 |  | Phone |  | Status |  |

1. **Creditor Information** - the business/individual to whom MHA should send the check if approved:

|  |  |  |  |
| --- | --- | --- | --- |
| Creditor Name  |  | Address |  |

|  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| City |  | State |  | Zip |  | Phone |  | Account # |  |

1. **Employment/Income Information**

|  |  |  |  |
| --- | --- | --- | --- |
| Employer  |  | Address |  |

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| City |  | State |  | Zip |  | Phone |  |

|  |  |
| --- | --- |
| List of employers of other household members |  |

**TOTAL Monthly Household Income:** List ALL income from ALL other members of the household. Sources of income should 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.

|  |
| --- |
|  |

**Past Assistance**

|  |  |
| --- | --- |
| Have you applied for assistance from MHA in the past year? (Y/N) |  |
| If YES, please provide month/year |  |

**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.  |

**PLEASE NOTE**:

* The Midwest Hemophilia Association (MHA) grants are never made directly to applicants/individuals, only to creditors that can be verified by MHA.
* Assistance is limited to a maximum of $500 per household. 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.

By signing below, you verify that the information you have provided to be true and accurate.

|  |  |  |  |
| --- | --- | --- | --- |
| SIGNATURE |  | DATE |  |

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

**Midwest Hemophilia Association**

**1467 W. South St., Suite C**

**Ozark, MO 65721**

**OR**

**Email:** **info@midwesthemophilia.org**

**------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------**

**MHA Office Use Only**

|  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
|  | Approved |  | Disapproved | Check # |  | Amount |  | Date Check Mailed |  |