HEMOPHILIA ASSOCIATION OF SAN DIEGO COUNTY

EMERGENCY ASSISTANCE PROGRAM

Applicant Information & Financial Declaration

Hemophilia Association of San Diego County
3550 Camino Del Rio North, Suite 105
San Diego, CA 92108

HEMOPHILIA ASSOCIATION OF SAN DIEGO COUNTY

Emergency Assistance Application

Applicant Information

First Name: _____ Last Name: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Phone: (Home) _____ (Cell) _____

Email: _____

Employer: _____ Job Title: _____

Hematologist: _____ HTC: _____

Type of Bleeding Disorder: _____ Number of People Living in Household: _____

Please check which assistance you are requesting.

- ☐ Transportation
- ☐ Care/Treatment of Bleeding Disorder
- ☐ Other related health needs
- ☐ Food
- ☐ Disability Access
- ☐ Other: _____

Please check off other resources you have recently requested for your current situation prior to this request from HASDC. Include date assistance was requested.

- ☐ San Diego Food Bank | Date: _____
- ☐ Cal Fresh | Date: _____
- ☐ Phone Bill Assistance | Date: _____
- ☐ SDGE Low Income Rate | Date: _____
- ☐ 211 San Diego | Date: _____
- ☐ Housing Subsidy (section 8) | Date: _____
- ☐ Transportation Voucher | Date: _____
- ☐ SSI/SSDI
- ☐ Family Member/Friend
- ☐ Other _____

Description of current need:

Please explain what led to this emergency:

Let us know how you plan to improve the situation in the future:

HEMOPHILIA ASSOCIATION OF SAN DIEGO COUNTY

Emergency Assistance Application
Financial Declaration

I, _____, hereby declare that I am unable to meet my financial responsibilities and that I am applying for the one-time yearly emergency assistance program through the Hemophilia Association of San Diego County, in a total amount not to exceed $250.00. As support for this declaration, I submit the following financial evidence:

Monthly Net Household Income

Applicant	_____	Net Income: $ _____
Spouse/Partner	_____	Net Income: $ _____
Roommate	_____	Net Income: $ _____
Other	_____	Net Income: $ _____
Other	_____	Net Income: $ _____
		TOTAL INCOME: $ _____

Monthly Net Household Expenses
List all expenses for the requesting month. To help support your evidence, please provide pertinent receipts or documentation.

Rent/Mortgage	$ _____
Food	$ _____
SDG&E	$ _____
Home Phone	$ _____
Cell Phone	$ _____
Cable/Internet	$ _____
Water	$ _____
Garbage	$ _____
Public Transportation	$ _____
Medical Bills	$ _____
Health Insurance	$ _____
Childcare	$ _____
Other: _____	$ _____
Other: _____	$ _____
Other: _____	$ _____
TOTAL EXPENSES:	**$ _____**

Applicant Signature: _____ Date: _____

Submitting the above request does NOT guarantee payment. Approval is at the discretion of the Hemophilia Association of San Diego County and is dependent on the availability of funds. Please allow up to two weeks for processing and response. Please complete the entire form and send to HASDC via fax at 619.325.4350, email to info@hasdc.org or mail to HASDC office. For guidelines please visit www.hasdc.org.

For Internal Use Only:

Date Application Received: _____