

Submitting this request does NOT guarantee funding. Approval is at the discretion of the Hemophilia Association of San Diego County (HASDC) and is contingent on availability of funds.

APPLICANT INFORMATION	
Date of Application:	
Applicant Name:	
Applicant Date of Birth:	
Applicant is (check one):	<input type="checkbox"/> Person with bleeding disorder <input type="checkbox"/> Parent/Legal Guardian of a minor, living in my household, with a bleeding disorder <ul style="list-style-type: none"> <li>• Type of Bleeding Disorder: _____</li> </ul>
Applicant Address:	
City   State   Zip:	
Home Phone:	
Cell Phone:	
Email:	

HOUSEHOLD INFORMATION				
List all people, including applicant, living in the home; indicate bleeding disorder diagnosis if applicable or relationship to applicant.				
Household Member Name	Date of Birth	Age	Bleeding Disorder Diagnosis & Severity	Relationship to Applicant
			<input type="checkbox"/> Hem A <input type="checkbox"/> Hem B <input type="checkbox"/> VWD <input type="checkbox"/> Other <input type="checkbox"/> Mild <input type="checkbox"/> Moderate <input type="checkbox"/> Severe If other, please specify:	
			<input type="checkbox"/> Hem A <input type="checkbox"/> Hem B <input type="checkbox"/> VWD <input type="checkbox"/> Other <input type="checkbox"/> Mild <input type="checkbox"/> Moderate <input type="checkbox"/> Severe If other, please specify:	
			<input type="checkbox"/> Hem A <input type="checkbox"/> Hem B <input type="checkbox"/> VWD <input type="checkbox"/> Other <input type="checkbox"/> Mild <input type="checkbox"/> Moderate <input type="checkbox"/> Severe If other, please specify:	
			<input type="checkbox"/> Hem A <input type="checkbox"/> Hem B <input type="checkbox"/> VWD <input type="checkbox"/> Other <input type="checkbox"/> Mild <input type="checkbox"/> Moderate <input type="checkbox"/> Severe If other, please specify:	
			<input type="checkbox"/> Hem A <input type="checkbox"/> Hem B <input type="checkbox"/> VWD <input type="checkbox"/> Other <input type="checkbox"/> Mild <input type="checkbox"/> Moderate <input type="checkbox"/> Severe If other, please specify:	
			<input type="checkbox"/> Hem A <input type="checkbox"/> Hem B <input type="checkbox"/> VWD <input type="checkbox"/> Other <input type="checkbox"/> Mild <input type="checkbox"/> Moderate <input type="checkbox"/> Severe If other, please specify:	

Please fill out completely and email to [info@hasdc.org](mailto:info@hasdc.org) or mail to the HASDC office.

**A copy of the outstanding bill, lease, or invoice is *required* and must be attached to this form.**

REFERRAL INFORMATION	
Referred to HASDC by: (cannot be staff/board member of HASDC)	
Referral Email:	
Referral Relationship:	
Social Worker:	

TREATMENT INFORMATION	
Are you seen at a Hemophilia Treatment Center? <input type="checkbox"/> Yes <input type="checkbox"/> No	
If yes, please name center: _____	
If no, please name where you are seen: _____	
Bleeding Disorder Physician:	

INSURANCE	
What type of health insurance do you have? Please check all that apply.	
<input type="checkbox"/> MediCal	<input type="checkbox"/> GHPP
<input type="checkbox"/> CCS	<input type="checkbox"/> Medicare
<input type="checkbox"/> Private Insurance	<input type="checkbox"/> Uninsured

PUBLIC ASSISTANCE	
Does your household receive any public assistance? Please check all that apply.	
<input type="checkbox"/> San Diego Food Bank	<input type="checkbox"/> SDGE Low Income Rate
<input type="checkbox"/> Cal Fresh	<input type="checkbox"/> 211 San Diego
<input type="checkbox"/> Phone Bill	<input type="checkbox"/> Housing Subsidy (Section 8)
<input type="checkbox"/> WIC	<input type="checkbox"/> SSI/SSDI
<input type="checkbox"/> Stimulus Check (please include amount received) \$ _____	

If you have you applied for Utility Payment or Rate Reduction Assistance through your local water, power, natural gas and telephone companies, did you qualify for the discounted rate or assistance? Please explain.

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CREDITOR INFORMATION	
Name of Creditor(s): (Business or individual to whom HASDC would send payment to).	
Billing Account Number(s):	
Address of Payee(s):	
Payee City   State   Zip:	
Request Amount:	
Is this a grocery request?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Are you currently at risk for utility shut off due to overdue bills? If so, what is the date utilities will be shut off?	
Date: ____ / ____ / ____	

INCOME INFORMATION	
Please list names and monthly income for <b>EACH</b> person living in the household.	
Name	Monthly Income (wages, SSI, SSDI, welfare, child support, alimony, unemployment benefits, DI, PFL, etc.)
1.	
2.	
3.	
4.	
Annual Household Income: (total from above) \$ _____	

MONTHLY EXPENSES	
Please list <b>ALL</b> monthly expenses for your household.	
Expense \$	Description of Expense
1.	
2.	
3.	
4.	
5.	
Have you applied for assistance from HASDC in the past year? If yes, please give provide the following information.	
Date: ____ / ____ / ____      Amount \$ _____	
Purpose:	

Please fill out completely and email to [info@hasdc.org](mailto:info@hasdc.org) or mail to the HASDC office.

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ADDITIONAL INFORMATION	
<p>HASDC's Financial Assistance Program should be considered a last option. Please list 3 other resources (organizations, friends, family, church, etc.) you have asked for assistance prior to the chapter. (Cannot be staff/board member of HASDC).</p>	
Name	Phone Number
1.	
2.	
3.	
<p>Brief description of circumstances that lead to this hardship:</p>	
<p>Brief description of plan to improve the situation:</p>	
<p>Is this request being made due to a recent change in employment or lost wages?</p> <p><input type="checkbox"/> Yes</p> <p><input type="checkbox"/> No</p> <p>If you answered YES:</p> <p>Have you filed for unemployment insurance?    <input type="checkbox"/> Yes    <input type="checkbox"/> No.    <input type="checkbox"/> Does not apply</p> <p>Have you filed for a disability claim (DI)?    <input type="checkbox"/> Yes    <input type="checkbox"/> No.    <input type="checkbox"/> Does not apply</p> <p>Have you filed for Paid Family Leave (PFL)?    <input type="checkbox"/> Yes    <input type="checkbox"/> No.    <input type="checkbox"/> Does not apply</p>	
<p>Have you had any recent changes in health that are related to this request?</p> <p><input type="checkbox"/> Yes</p> <p><input type="checkbox"/> No</p> <p>If yes, please explain:</p>	

Please note: HASDC FAP requests are never made directly to individuals, only to creditors that can be verified with HASDC. Because of limited resources, requests for financial assistance may be granted one time per 12-month period per household and granted up to \$500.00 for one single request. Any additional requests for emergency financial assistance within 1 year must be appealed to the Board of Directors. Please allow up to 2 weeks for your application to be processed. I have read and understand the HASDC policy for the Financial Assistance Program.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_