HASDC
HEMOPHILIA ASSOCIATION OF SAN DIEGO COUNTY

FINANCIAL ASSISTANCE PROGRAM APPLICATION

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):	☐ Person with bleeding disorder ☐ Parent/Legal Guardian of a minor, living in my household, with a bleeding disorder • Type of Bleeding Disorder: ___________________________
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
			☐ Hem A ☐ Hem B ☐ VWD ☐ Other ☐ Mild ☐ Moderate ☐ Severe If other, please specify:	
			☐ Hem A ☐ Hem B ☐ VWD ☐ Other ☐ Mild ☐ Moderate ☐ Severe If other, please specify:	
			☐ Hem A ☐ Hem B ☐ VWD ☐ Other ☐ Mild ☐ Moderate ☐ Severe If other, please specify:	
			☐ Hem A ☐ Hem B ☐ VWD ☐ Other ☐ Mild ☐ Moderate ☐ Severe If other, please specify:	
			☐ Hem A ☐ Hem B ☐ VWD ☐ Other ☐ Mild ☐ Moderate ☐ Severe If other, please specify:	
			☐ Hem A ☐ Hem B ☐ VWD ☐ Other ☐ Mild ☐ Moderate ☐ Severe If other, please specify:	

Please fill out completely and email to info@hasdc.org , fax to 619.325.4350, or mail to the HASDC office.

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

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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? ☐ Yes ☐ 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.	
☐ MediCal	☐ GHPP
☐ CCS	☐ Medicare
☐ Private Insurance	☐ Uninsured

PUBLIC ASSISTANCE	
Does your household receive any public assistance? Please check all that apply.	
☐ San Diego Food Bank	☐ SDGE Low Income Rate
☐ Cal Fresh	☐ 211 San Diego
☐ Phone Bill	☐ Housing Subsidy (Section 8)
☐ WIC	☐ SSI/SSDI
☐ 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:	
Type of Request:	☐ Rent ☐ Utilities ☐ Groceries ☐ Gas Card ☐ Other
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 **EACH** 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 **ALL** 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:	

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ADDITIONAL INFORMATION	
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).	
Name	Phone Number
1.	
2.	
3.	

Brief description of circumstances that lead to this hardship:

Brief description of plan to improve the situation:

Is this request being made due to a recent change in employment or lost wages?

☐ Yes
☐ No

If you answered YES:

Have you filed for unemployment insurance? ☐ Yes ☐ No. ☐ Does not apply

Have you filed for a disability claim (DI)? ☐ Yes ☐ No. ☐ Does not apply

Have you filed for Paid Family Leave (PFL)? ☐ Yes ☐ No. ☐ Does not apply

Have you had any recent changes in health that are related to this request?

☐ Yes
☐ No

If yes, please explain:

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: _____

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