Family Assistance Form - Request for Services

Personal Information Section

LAST NAME: _____

FIRST NAME: _____ MIDDLE INITIAL: _____

ADDRESS: _____

CITY: _____ STATE: _____ ZIP: _____

PHONE: (HOME) _____ (CELL) _____

EMAIL: _____

DATE OF BIRTH: _____

PARENT/GUARDIAN NAME (IF MINOR): _____

This request will be forwarded to the Virginia Hemophilia Foundation. In the interest of privacy, identifying information will be removed from the request and forwarded to a blinded committee for review. Additional information may be required. All payments will be made directly to the party that is owed the monies. Please attach all supporting information including copies of bills and payment page. Applicants will be informed of the outcome of the committee review.

_____ Date: _____
Applicant (or parent/guardian)

Approved ___ Denied ___ Date _____

Reason for Denial (if applicable)

_____
_____
_____
_____

Section 2 – Blinded Information for Submittal

NUMBER OF FAMILY MEMBERS IN HOUSEHOLD:
ADULTS: _____ CHILDREN (<19): _____

INCOME:
EMPLOYED: _____

FULL TIME: _____ PART TIME: _____ MONTHLY INCOME: $_____

SSI OR WELFARE MONTHLY: $_____ UNEMPLOYMENT COMPENSATION: $_____

OTHER SOURCES OF INCOME: $_____

PLEASE DESCRIBE: _____
_____
_____

EXPENSES (monthly):
HOUSING: $_____ UTILITIES: $_____ PHONE: $_____

INSURANCE: $_____ CAR: $_____ OTHER: $_____

INSURANCE INFORMATION:
PRIVATE: _____ MEDICARE: _____ MEDICAID: _____

AMOUNT REQUESTED: $_____ ($250 maximum)

What is the purpose of the requested amount? _____
_____
_____

Is this a one-time expense _____ or a monthly expense _____?

If monthly, what are you doing to ensure that this bill will be paid next month?
_____
_____
_____

Have you applied to any other organizations for assistance for this particular bill?
_____
_____
_____

Please email completed application to: info@vahemophilia.org

Or mail to Virginia Hemophilia Foundation:
410 N. Ridge Rd., Suite 215
Richmond, VA 23229