VHF Financial Assistance Program
Request For Services Form

Last Name: _____ First Name: _____

If under 18, provide the name of your Parent/Guardian:

_____

Address: _____

City: _____ State _____ Zip: _____

Cell Phone: _____ Email: _____

How did you hear about VHF's Financial Assistance Program?

_____

If you were referred by a healthcare provider, please list their name and contact info: _____

_____

Have you or a family member ever received financial assistance from VHF?

Yes __ No __

If yes, when? _____

What type of inherited bleeding disorder do you and/or your family/household member have? _____

What is your relationship to the person with an inherited bleeding disorder?

_____

Where does the person with an inherited bleeding disorder receive treatment for their bleeding disorder? _____

Please email completed application to: info@vahemophilia.org

NOTE: Successful applicants will coordinate requests with a social worker and/or nurse coordinator at a hemophilia treatment center or other healthcare provider treating bleeding disorders, which includes having them review your application and forwarding the application and/or submitting a referral to info@vahemophilia.org. For questions info@vahemophilia.org or (804) 740-8643.

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What type of insurance do you have?
Private: ___ Medicare: ___ Medicaid: ___ Other: ___

If you answered other, please explain: _____

_____

Number of people living in the household? Adults: ____ Children (under 18): ____

Income (monthly): $_____ Expenses (monthly): $_____

Amount Requested: $_____ (up to $500)

What is the purpose of the requested amount? _____

_____

Is this a one-time expense or a monthly expense? One-time: _____ Monthly: ____

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

_____

What other organizations have you applied to for assistance?

_____

Additional Comments/Notes: _____

_____

This request will be forwarded to the Virginia Hemophilia Foundation (VHF) Scholarship Committee. Identifying information will not be shared with the committee. Additional information may be required. All payments will be made directly to the party that is owed the monies.

_____
Signature of Applicant (or parent/guardian)

Date: _____

Please email completed application to: info@vahemophilia.org

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