Hemophilia Foundation of Southern California

EMERGENCY FINANCIAL ASSISTANCE APPLICATION

Submitting this request does not guarantee funding. Approval is at the discretion of the Hemophilia Foundation of Southern California and is contingent on availability of funds.

Please fill out completely and email to info@hemsocal.org, fax to 626-765-6657 or mail to Hemophilia Foundation of Southern California.

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

Date of Application:	
Applicant Name:	
Applicant Date of Birth:	
Applicant is (check one):	☐Person with bleeding disorder ☐Parent/Legal Guardian of a person with a bleeding disorder ☐Other: _____

Household Members: List all people **including applicant** residing in 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**
			□Hemo A □Hemo B □VWD □Other □Mild □Moderate □Severe If other, please specify:	
			□Hemo A □Hemo B □VWD □Other □Mild □Moderate □Severe If other, please specify:	
			□Hemo A □Hemo B □VWD □Other □Mild □Moderate □Severe If other, please specify:	
			□Hemo A □Hemo B □VWD □Other □Mild □Moderate □Severe If other, please specify:	
			□Hemo A □Hemo B □VWD □Other □Mild □Moderate □Severe If other, please specify:	

Applicant Address:	
City/State/ZIP:	
Home Phone: Cell Phone:	
Email:	
Referred to HFSC By:	
Bleeding Disorder Physician:	
Hemophilia Treatment Center:	

Hemophilia Foundation of Southern California

EMERGENCY FINANCIAL ASSISTANCE APPLICATION

Referral Email:	
Referral Phone:	
Referral Relationship:	
Social Worker:	
What type of health insurance do you have? Please check all that apply.	☐ MediCal ☐ GHPP ☐ CCS ☐ Medicare ☐ Private Insurance ☐Uninsured
Does your household receive any public assistance (for example, MediCal, Medicare, WIC, TANF, CALFRESH, SSI, UI or SDI?)	☐No ☐Yes If so, have you applied for Utility Payment or Rate Reduction Assistance through your local water, power, natural gas, and telephone companies? If yes, did you qualify for discounted rates or assistance? Please explain.

Name of Creditor(s): (Business or individual to whom HFSC would send a check). Note: HFSC does not pay for rent without a valid lease	
Account Number(s):	
Address of Payee(s):	
Payee City/State/ZIP:	
Requested Amount:	
Are you at risk for utility shut off due to overdue bills? If so, what is the date utilities will be shut off?"	

Hemophilia Foundation of Southern California

EMERGENCY FINANCIAL ASSISTANCE APPLICATION

Income: Please list names and monthly income for each person in the household.		
Name	Monthly Income (wages, SSI, SSDI, welfare, child support, alimony, unemployment benefits, DI, PFL etc.)	
Annual Household Income:		
Monthly Expenses: Please list monthly expenses for your household.		
Expense: $	Description	
Have you applied for assistance from HFSC in the past? If yes, please give month/year and purpose	☐No ☐Yes	
Month	Year	Purpose of Funding
Additional Comments:		

The HFSC's EFA 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 Foundation.	
Name:	Phone:
Name:	Phone:
Name:	Phone:

Hemophilia Foundation of Southern California

EMERGENCY FINANCIAL ASSISTANCE APPLICATION

Brief Description of circumstances leading 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 yes, please explain:

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:

Have you ever signed up for an HFSC event and not attended without notifying the office prior to the event?
☐Yes ☐No
If yes, please explain: _____

Please describe your involvement with HFSC and/or the Bleeding Disorders Community:

Please note: HFSC grants are never made directly to individuals, only to creditors that can be verified with HFSC. Because of its limited resources, requests for emergency financial assistance may be granted one time per 12 month period per household and granted up to $500.00 for one single request. Any requests for emergency assistance within 1 year must be appealed to the Board of Directors. Waiting time can be up to 2 weeks. I have read and understood the HFSC policy for emergency financial assistance program.

Signature:_____ Date:_____

Return this form along with a copy of the bill(s), lease, etc. for which you are requesting assistance to:

Hemophilia Foundation of Southern California
959 E Walnut St., Suite 114 | Pasadena CA 91106
626-765-6657 (fax)
info@hemosocal.org

Hemophilia Foundation of Southern California

EMERGENCY FINANCIAL ASSISTANCE APPLICATION

HFSC Staff Only			
Approved?	☐Yes	☐No	Date:
Paid Amount:			
Method of Payment:			
Date of Payment:			
Notes:			