ASOCIACIÓN PUERTORRIQUEÑA DE
HEMOFILIA
Y CONDICIONES DE SANGRADO

EMERGENCY FINANCIAL ASSISTANCE APPLICATION
SOLICITUD DE ASISTENCIA FINANCIERA DE EMERGENCIA

Please review the Asociación Puertorriqueña de Hemofilia y Condiciones de Sangrado (APH) Emergency Financial Assistance Policy guidelines before submitting your application.
Por favor revise la póliza de Asistencia Financiera de Emergencia de APH antes de enviar su solicitud.

I have read and understand the Emergency Financial Assistance Policy guidelines.
Initial here: _____
He leído y entiendo las pautas de la Póliza de asistencia financiera de emergencia.
*Iniciales aquí:*_____

Completion of this application will automatically register you with the APH *and place you on the mailing list. If you do not wish to be placed on the mailing list, please initial here:* _____

Complete the following information in a different font or color if filling out electronically. Sign, scan, and either email, fax or send via postal mail:

BASIC INFORMATION

Today's Date: _____

Applicant's First and Last Name: (Parent's names in case of a minor.)

_____

Address (Street, City, State, and Zip):

_____

Phone number(s) (where you can be reached for follow up questions):

_____

Email Address: _____

Number of people living in the household: _____

Household income: (indicated per week, month, or year): _____

Type(s) of medical insurance? _____

Do you have Medicaid? _____

Employer(s): _____

Commented [MC1]: I think Medicaid may be called something different there. This would be a question for Anthony

Commented [er2R1]:

Marital status: _____

Spouse's name: _____

Is spouse employed? If so, by whom?: _____

The applicant is:

- ❒ Person with a bleeding disorder
- ❒ Parent of a minor child with a bleeding disorder
- ❒ Other: Please describe _____

Type of bleeding disorder: _____

EMERGENCY FINANCIAL ASSISTANCE REQUEST

Please describe your need for financial assistance:
Use as much detail as possible.

Describe how assistance will help resolve the current need:
Include as much detail as possible.

Please list any additional financial assistance requested for the current needs, dates, and outcomes of each request:
This is not required, but is recommended.

Amount requested (up to $500): _____
APH *is able to provide a maximum of $500 funding per person/family per rolling calendar year.*

When are these funds needed? _____
Please by aware that APH *may need up to two weeks to process a request.*

Have you applied for financial assistance from APH in the past? If so, please provide the month and year.

_____

Asociación Puertorriqueña de Hemofilia y Condiciones de Sangrado cannot provide funding directly to individuals, but if approved, APH will pay a vendor directly. Please list your bill payment information below and include copies of bills with contact information wherever possible. Please review the Emergency Financial Assistance policy for more information.

Applicant must sign an intended use agreement stating that the financial assistance received from the APH will be used for the purpose indicated on approved financial assistance. application.

Bill Payment Request

Company Name/Establishment: _____

Account number: _____

Mailing address (address, city, state, zip):

_____

_____

Phone: _____

Website (when available): _____

I, _____, certify that the information I have submitted is true and accurate to the best of my knowledge.

Signature: _____

Date: _____

Please submit via email to hemophilia.aph@gmail.com OR via mail to:

Asociación Puertorriqueña de Hemofilia y Condiciones de Sangrado
PMB 633, PO Box 29005,
San Juan, Puerto Rico 00929-0005

DO NOT WRITE BELOW THIS LINE

To be completed by Asociación Puertorriqueña de Hemofilia y Condiciones de Sangrado Emergency Financial Assistance Committee or Advisory Board Members Only

Request approved by: _____

Amount approved: _____

Check number: _____

Date fund assistance mailed: _____

Sent by: _____

Sent to: _____

Address (address, city, state, zip):

_____