HOPE FOR HEMOPHILIA

GIVING SEEDS OF HOPE THROUGH SEASONS OF CRISIS

Hope Assistance Application

Thank you so much for applying for assistance from Hope for Hemophilia. We exist to help patients who are suffering through crisis caused by hemophilia! We consider it our honor to try to help you through this difficult season.

We strive to be a conduit of hope, strength, and resources to patients and their families who are suffering through crisis. We evaluate ALL applications based on type of need, amount of assistance requested, and state of crisis. *We do not discriminate on the basis of age, race, sex, or religion.*

Your personal information is of the upmost importance to us and will be kept strictly confidential. By completing this application, you are giving Hope for Hemophilia permission to communicate with you about your application and send you information regarding and future events and education materials.

We ask that you please fill out this form completely. We need all the information requested so please don't ignore any of the blanks, unless it does not apply (ie: 2nd parent/guardian).

After you complete this application we will need some additional information.

We will need:

- A copy of a valid driver's license or government issued ID
- Copies of all bills that you are requesting assistance with
- Signed application

You may fax your application with supporting documents to 888-835-1449, email them to info@hopeforhemophilia.com or send them via the postal service to PO Box 77728 Baton Rouge, LA 70879.

Once we receive all of your information, your signed application and all supporting documents, we will start working on your request right away!

What can you expect?

- ✓ A Hope for Hemophilia team member will contact you within two business days after receipt of your application.
- ✓ Some applications can take up to two weeks to obtain a decision.
- ✓ If we request further information, your application will be delayed for decision until ALL information is gathered for your file.

Thank you for applying to become a recipient of hope! We will honor your time by having one of our team members carefully evaluate your application in person. We will take into consideration ALL of the information you have supplied and may request further information if needed.

If you have questions you may contact us anytime at info@hopeforhemophilia.com or by calling 888-529-8023.

Thank you for giving us the opportunity to serve you and your family through this very difficult season!

Sincerely,

Hope for Hemophilia Team

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Patient Information

Patient Name: ____ DOB: ___/___/_____
First Name Last Name MM DD YYYY

SSN: _________-______-____________ Grade/Occupation: _______________________________

Annual Household Income: ____

Address: ____ Apt/Ste #: __________

City: _____________________________________ ST: ______ ZIP: ___________

Cell: (______)____________________ Home Phone: (______)____________________

Email Address: ____

Parent/Guardian Information

Please complete if the patient is under 18 years of age

1) Parent/Guardian Name: ____________________________________ DOB: ___/___/_____
First Name Last Name MM DD YYYY

SSN: _________-______-____________ Grade/Occupation: _______________________________

Annual Household Income: ____

Address: ____ Apt/Ste #: __________

City: _____________________________________ ST: ______ ZIP: ___________

Cell: (______)____________________ Home Phone: (______)____________________

Email Address: ____

2) Parent/Guardian Name: ____________________________________ DOB: ___/___/_____
First Name Last Name MM DD YYYY

SSN: _________-_____-____________ Grade/Occupation: _______________________________

Annual Household Income: ____

Address: ____ Apt/Ste #: __________

City: _____________________________________ ST: ______ ZIP: ___________

Cell: (______)____________________ Home Phone: (______)____________________

Email Address: ____

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Tell us about your Hemophilia:

What type of bleeding disorder have you been diagnosed with?

- ○ Hemophilia A (Factor VIII)
- ○ Hemophilia B (Factor IX)
- ○ Von Willebrand
- ○ Other ______________________________

What Hemophilia Treatment Center do you visit? ______________________________

What is the name of your Hematologist/Doctor? ______________________________

Are you a member of a local Hemophilia organization, or chapter? (If so, please list)

____

How did you hear about Hope for Hemophilia?

____

What organization referred you to Hope for Hemophilia? ________________________

Name of person who referred you: ______________________________

May we contact them for reference? ○ YES ○ NO (If yes, please provide contact info)

Phone: ________________________ Email: ______________________________

Tell us your hemophilia story:

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How can we help?

In order for us to help you best, we need to know what other organizations you have applied for or have helped you during this difficult season.

Please list the other organizations you have applied for assistance from and the most recent status:

Tell us about the challenges you are facing now and why you need assistance at this time?

What financial needs do you have? (Please list bills in order of priority)

What is your single most pressing need at this time? ______________________________

How much is the total amount of financial support you are requesting? $ ______________

** By signing this document you are stating that all information given on this application is completely accurate and true.

Signature: ______________________________ Date: ______________

Patient (Parent or Legal Guardian if patient is a minor)

Please email this signed application along with a copy of a valid drivers license (or government issued ID), and copies of bills for any financial assistance requested, to info@hopeforhemophilia.com or fax to 888-835-1449.

01/25/2019

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Patient Privacy and Consent

The information you provide will be used by Hope for Hemophilia, Hope Charities, and parties acting on their behalf to determine eligibility, to manage and improve Hope for Hemophilia's assistance programs, to communicate with you about your experience with Hope for Hemophilia's assistance programs, and/or to send you materials and other helpful information and updates relating to Hope for Hemophilia's programs.

I understand that:

- Completing this application does not guarantee that I will qualify for Hope for Hemophilia's assistance programs.
- I agree to provide all requested documentation in a timely manner.
- Payments cannot be disbursed until I submit this documentation and that it is my responsibility to ensure that my accounts do not default.
- Hope for Hemophilia is not responsible for any cancellation of service or coverage.
- If approved, I certify that I will notify and provide documentation of any changes in my income or financial situation that may impact upcoming assistance.
- Failure to provide any requested information may jeopardize further assistance.
- If approved, I agree to promptly return to Hope for Hemophilia any refund check from a company due to overpayment resulting from assistance.
- Hope for Hemophilia may verify the accuracy of the information I have provided and may ask for more information.
- Hope for Hemophilia reserves the right to change or cancel Hope for Hemophilia's assistance programs, or terminate my enrollment, at any time.

I give consent, and hereby authorize, Hope for Hemophilia to verify the information contained in this application and in all supporting documentation. Hope for Hemophilia may contact any company, agency, medical office, records bureau, insurance carrier, referral source, case manager, treatment center, doctor, nurse, or service provider to obtain any further necessary information in the course of assistance review and, if approved, disbursement. Hope for Hemophilia is permitted to phone, fax, write, or email with any company from which I submit a bill, invoice, or statement as part of this grant application. All records, including records in these subject areas financial, medical history and treatment, vocational records, case management, treatment plans (including hospice advance directives) may be shared with, released to, provided to, etc. Hope for Hemophilia. This information has been disclosed to Hope for Hemophilia from records which may be protected by state and/or federal laws that protect confidentiality. These laws prohibit Hope for Hemophilia from making further disclosure of this information without the specific written consent from the applicant, or as otherwise permitted by state law. Any and all information pertaining to grant applicants, grant applicant's medical records, medical information, financial information, etc. is strictly confidential and proprietary to Hope for Hemophilia consistent with the Health Insurance Portability and Accountability Act of 1996 (HIPAA). I release each any of the involved companies, agencies, institutions, persons, etc. and the Hope for Hemophilia staff and counsel from all legal responsibility or liability that may arise from authorized release of this information. I understand and that I may revoke this consent at any time. This consent expires one year after the date signed.

By signing, I attest that I have read the above and agree to abide by the policies of Hope for Hemophilia as outlined in this application and through all other correspondence with Hope for Hemophilia.

Signature: ______________________________ Date: ____________________

Print Name: ____

PO Box 77728 Baton Rouge, LA 70879
Phone: (888) 529-8023 Fax (888) 835-1449

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