



CENTRAL OHIO CHAPTER
NATIONAL HEMOPHILIA FOUNDATION
for all bleeding and clotting disorders

Emergency Financial Assistance Program Application

Date: _____ Submitted by: _____

Applicant's Name: _____

Signature of family member to release info to chapter: _____

County: _____

Phone Number: _____

Assistance needed for: _____ Date due: _____

Description of circumstances surrounding request and how funds will be used: _____

Amount requested: _____

Check payable to: _____

Address/City/ST/Zip: _____

Contact Name: _____

Phone number: _____

Please e-mail to: ralexander@hemophilia.org

Or Fax to: 614-429-2150

Criteria for dispensing Special Needs Funds:

- Confidentiality of all applicants and nature of request by all Board members involved.
- Applicant has not exceeded the \$1500 lifetime cap. If so, would need executive committee approval.
- Executive Director and Social Worker from HTC discuss case and resolution.
- \$250 or less, Executive Director approves. Over \$250, an executive committee approves.
- No cash is given and no payment is ever made directly to applicant.
- Feedback to Board quarterly on applications and funds given during the quarter.