Financial Assistance and Financial Aid Fund Application Form

Please Print Clearly:

Personal Information Section

1. Applicants Name: _____

   Address: _____

   City:_____State:_____Zip: _____

   E-mail:_____Phone 1: (C) _____
   Phone 2: (H) _____

   Year of Birth: _____ Current age: _____

   Parent / Guardian Name (If Minor): _____

Financial need is being requested for?

_____
_____
_____
_____
_____
_____

✓ Please Check the Appropriate Financial Need:

_____ Medical Alert ID

_____ Travel Grant - (*Please Provide Total Miles to Travel)* _____

_____ Basic Living Expenses

_____ Medical Expenses

_____ Dental Services

_____ Mental Health Services

Financial Need Requested: $_____

This request will be forwarded to the Financial Assistance Committee of Bleeding Disorders Association of South Carolina. In the interest of privacy, identifying information will be removed from the request and forwarded to a blinded committee for review. Additional information may be required.

All payments will be made directly to the party that is owed the monies. Please attach all supporting information including copies of bills and payment page. Applicants will be informed of the outcome of the committee review.

To the best of my knowledge, I hereby attest that the above information is correct and accurate.

_____ **Date**:_____

Applicant (or parent/guardian

For internal processes:

Approved_____Denied_____Referred to other resources: HFA_____

Date: _____

Reason for denial (if applicable)

_____

_____

_____

_____

Signature of BDASC Assistance Member:

_____

Section 2 – Blinded Information for Submittal

The applicant is:

_____ An adult with a bleeding disorder
_____ A caretaker of someone with a bleeding disorder living in your household
_____ A parent of a minor child with a bleeding disorder. Please include the age of the child with the bleeding disorder (_____) years. Year of Birth_____
_____Other, please explain_____

How many family members in your household?

Adults:_____Children (Under 18)_____

Did someone refer you to the BDASC Financial Aid Program? Yes___No_____
If referred, who is making the referral services?_____

Have you applied for assistance from any other sources, and if so, what is the status of that application?

_____

_____

What is the applicant's annual household income?

_____ Unemployed
_____ Less than $15,000
_____ $16,000 - $35,000
_____ $36,000 - $50,000
_____ $51,000 or greater

Name of Employer:_____

Address of Employer: _____

Phone Number of Employer: _____

Creditor: Please supply the business or individual whom BDASC should make payment:

Name: _____
Complete Address: _____
Account / Invoice Number: _____

Medical Facility or HTC and Treating Physician:

_____**Phone Number**_____

Name of Physician: _____

Have you applied for assistance from BDASC in the past year? _____ Provide date: _____

Please mail, e-mail scan, or fax application to: Bleeding Disorders Association of South Carolina
Attn: Financial Assistance Program *(See address information in the footnote section)*
Email Address: Info@bda-sc.org