ARIZONA BLEEDING DISORDERS
Formerly Arizona Hemophilia Association

EMERGENCY SPECIAL ASSISTANCE REQUEST FORM

Submitting this request does not guarantee payment. Approval is at the discretion of the Arizona Bleeding Disorders (AzBD) and is contingent on availability of funds for this program. Assistance is limited to a maximum of $300.00 per calendar year.

Eligibility Guidelines:

- Applicant must be a resident of Arizona and an active Member of the Arizona Bleeding Disorders.
- Applicant must have a diagnosed bleeding disorder or be the parent or guardian of a minor child who lives in the same household who has a diagnosed bleeding disorder.
- The Applicant must have not received Emergency Assistance from the AzBD within the last 365 days.
- A copy of the outstanding bill or invoice is required and must be included with this application.
- Applicant must complete all sections of the application thoroughly and accurately and provide corresponding documentation if requested.

Please ***return*** the completed application via mail, fax or e-mail to the Attention of Member Services:
Fax Number:(602-955-1962)
Mail: Arizona Bleeding Disorders 826 N 5th Ave, Phoenix Arizona 85003
E-Mail: memberservices@arizonahemophilia.org

Community Member Name: ______________________________ Date of Birth: ____/____/____

Address: ____

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Telephone Number: (Home)_________________(Cell)________________(Work)_________________

E-Mail Address: ____

Members name who is diagnosed with a bleeding disorder: ___________________________________

Date of Diagnosis: _________________________________Date of Birth:_____/_____/________

Invoice Bill Information

Name of Payee: __________________________________Acct. # ____________________________

Address of Payee: ____

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Requested Amount:___________________ Bill Due Date: ___________________________

The AHA's assistance program should be considered a last option. Please list three other resources you have asked for assistance prior to the Association.

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1. ______________________________ Telephone #: ____________________

2. ______________________________ Telephone #: ____________________

3. ______________________________ Telephone #: ____________________

Brief description of circumstances leading to this hardship:

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Brief description of plan to improve the situation:

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I certify that the information I have provided in this application is true and correct. I consent to the release of this information in this application to the Arizona Bleeding Disorders or other social service agencies, groups, HTC's, utility companies, etc which may assist and contribute to receiving emergency assistance funds.

____________________	____________________	____________________
Print Name	Signature	Date

AHA Staff Only:

Paid Amt:	Method of Payment:	Date of Payment:
Given to Accounting: Y N	Entered to Log: Y N	

FORMULARIO DE SOLICITUD PARA AYUDA ESPECIAL