

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: _____

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: _____

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.

