

Hemophilia Foundation of Greater Florida Emergency Assistance Request

1350 North Orange Avenue • Suite 227 • Winter Park FL 32789 • 407-629-0000 • 800-293-6527 • Fax 407-629-9600

| | | |
|-------------------|-------------|--------------|
| Name of Requester | Soc. Sec. # | D.O.B / / |
|-------------------|-------------|--------------|

| | | |
|-----|---|---|
| Age | Marital Status: <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Separated <input type="checkbox"/> Divorced | Gender: <input type="checkbox"/> M <input type="checkbox"/> F |
|-----|---|---|

| | | | | | |
|---------|-------|------|-------|-----|----------|
| Address | | | | | How long |
| Street | Apt # | City | State | Zip | County |

| | | |
|----|-------|-------|
| HP | Cell | Fax |
| WP | Pager | Email |

| | | | | |
|----------|-----------------|------------------|------------|----------------|
| Employer | Supervisor Name | Supervisor Phone | Occupation | Monthly Income |
|----------|-----------------|------------------|------------|----------------|

| | | |
|-------------|-------------|--------------|
| Other Adult | Soc. Sec. # | D.O.B / / |
|-------------|-------------|--------------|

| | | |
|-----|---|---|
| Age | Marital Status: <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Separated <input type="checkbox"/> Divorced | Gender: <input type="checkbox"/> M <input type="checkbox"/> F |
|-----|---|---|

| | | |
|----|-------|-------|
| HP | Cell | Fax |
| WP | Pager | Email |

| | | | | |
|----------|-----------------|------------------|------------|----------------|
| Employer | Supervisor Name | Supervisor Phone | Occupation | Monthly Income |
|----------|-----------------|------------------|------------|----------------|

Other Members in Household (List additional members on a separate sheet and attach.)

| Name | Soc. Sec. # | D.O.B. | Age | Relationship |
|------|-------------|--------|-----|--------------|
| | | | | |
| | | | | |
| | | | | |
| | | | | |
| | | | | |

| Monthly Income | | Monthly Expenses | | Explain specific need in detail: Attach Additional Information _____ _____ _____ _____ _____ _____ _____ _____ _____ _____ _____ _____ _____ Monetary Value: _____ |
|-----------------|-----------|------------------|-----------|--|
| Employment | \$ | Rent/Mort | \$ | |
| Unemployment | \$ | Electric | \$ | |
| W. Comp | \$ | Water | \$ | |
| Pension | \$ | Propane | \$ | |
| Child Support | \$ | Home Phone | \$ | |
| Social Security | \$ | Food | \$ | |
| SSI | \$ | Car Paym | \$ | |
| SSD | \$ | Car Ins | \$ | |
| AFDC | \$ | Credit Cards | \$ | |
| Food Stamps | \$ | Cell Phone | \$ | |
| Bank Accounts | \$ | Cable/Internet | \$ | |
| Total | \$ | Total | \$ | |

State why income is not available for this emergency:

**All sections must be filled out correctly and supporting document(s) must be attached prior to processing.
We will not process the application until we receive all documentation.
 Applications that are incomplete, may be denied**

Release of Information/Applicant Attestation: *I certify that the information I have provided in the above is true and correct. I consent to the release of pertinent information contained in this application to the Hemophilia Foundation of Greater Florida, Inc., other social service agencies which distribute emergency financial assistance, the company or individual to receive funds as necessary to complete the services to my household, or to provide statistics on emergency assistance, or as a guard against duplicate assistance. I also consent to release of patient information to the federal government and those utility companies which require documentation of recipient's funds.*

Signature: _____ **Date:** _____

