Hemophilia of North Carolina

Financial Assistance Program

APPLICATION FORM

Please PRINT:

1. Name: _____

   Address: _____

   City: _____ State: ____ Zip: _____ Phone 1: _____

   Email: _____ Phone 2: _____

2. Who referred you to HNC? _____ Date: _____

   May we contact this person? No: _____ Yes: _____ If yes, please list their phone #: _____

3. Amount requested: $_____ When are these funds needed? _____

4. Reason for this request: _____

   _____

   _____

   _____

   _____

5. Names, phone numbers, and status (granted, denied, pending, etc.) of other agencies or sources of funds to whom you have applied for this aid – List TWO (2):

   1. Name: _____ Ph: _____ Status: _____

   2. Name: _____ Ph: _____ Status: _____

6. Creditor – the business or individual to whom HNC should send a check:

   Name: _____

   Address/City/State/Zip: _____

   Phone: _____ Account # (if applicable): _____

(continued on next page ...)

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7. The applicant is:

   ___ Person with bleeding disorder

   ___ Parent of a minor child with a bleeding disorder (Name: _____ Age: _____)

   ___ Other (please describe relationship:_____)

   Type of bleeding disorder: _____

   (Factor VIII, IX, von Willebrand, etc.)

8. Employer: _____

   Address/City/State/Zip: _____

9. Marital status: _____ Spouse's name: _____

   Is spouse employed? _____ If so, by whom? _____

   Spouse employer's Address/City/State/Zip: _____

10. Annual household income: _____

11. Have you applied for assistance from HNC in the past?

    No: _____ Yes: _____ If yes, please give month/year: _____

12. Signature: _____ Date: _____

PLEASE NOTE: *Hemophilia of North Carolina (HNC) grants are never made directly to individuals, only to creditors that can be verified by HNC. Because of its limited resources HNC does not make grants in excess of $500 per calendar year. HNC assistance is limited to two consecutive years. After two years, applicants must wait one year before applying again for assistance.*

Personal information will not be used or disclosed for purposes other than those for which it was collected. At no time is personal information shared with any individual, company or organization outside of HNC.

OPT-OUT: Check here ❑ if you prefer NOT to be added to the HNC database.

Return this form, along with **a copy of the bill** for which you are requesting assistance, to:

HEMOPHILIA OF NORTH CAROLINA
260 TOWN HALL DRIVE, SUITE A
MORRISVILLE, NC 27560

OR FAX TO: (919) 319-0016

Questions? Call HNC at (800) 990-5557