Hemophilia of North Carolina

Financial Assistance Program

APPLICATION FORM

Please Print:

1. Applicant Information:**

Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone 1: _____ Email: _____

Phone 2: _____

2. Referral Information:

Who referred you to HNC? _____

May we contact this person? (Y/N) _____ Phone No: _____

Are you a patient at HTC? (Y/N) _____Which HTC? _____

3. Request for Assistance:

Amount requested: _____ Date needed: _____

Reason for this request: _____

_____

_____

_____

_____

4. HNC requires applicants first seek assistance from two agencies before applying to HNC. Please identify these agencies below:

Name: _____ Ph: _____ Status: _____

Name: _____ Ph: _____ Status: _____

5. Creditor - the business/individual to whom HNC should send the check:

Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone: _____ Account No: _____

**Parents of adult children with a bleeding disorder or spouses of a person with a bleeding disorder may NOT apply on behalf of their spouse or adult child unless they provide an explanation of disability that prevents the adult with a bleeding disorder from applying on their own behalf.

Revised February 6, 2018

6. Please list ALL members of the household (including non-family members).

Name	Age	Does this person have a bleeding disorder?	Type of bleeding disorder	Relationship to person with bleeding disorder*
Applicant				

*Types of relationships can include: self, spouse, parent, sibling, roommate, etc.

7. Employment Information:

Applicant's Employer: _____

Address: _____

City: _____ State: _____ Zip: _____

List of employers of other household members: _____

_____

_____

TOTAL Monthly Household Income: _____

_____

(List **ALL** income from **ALL** other members of the household. Sources of income can include: employment wages, unemployment, SSI/SSDI/SSD, Food Stamps, spousal/child support, assistance from relatives, etc. HNC reserves the right to request a copy of your most recent tax return for verification of income.)

8. Past Assistance:

Have you applied for assistance from HNC in the past? (Y/N): _____

If yes, please give month/year: _____

(continued on next page...)

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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.***

Submittal of Bill: All pages of the bill in question must be submitted to HNC before the application for financial assistance can be reviewed. Please check the option below that applies:

☐ I am attaching complete documentation of the bill to this application.

☐ I need to send complete documentation of the bill separately. Explain: _____

_____

_____

SIGNATURE: _____ **DATE:** _____

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

**HNC maintains its own private database of contact information that is used to send out information relevant to people with bleeding disorders, including events around the state. If you wish to be removed from the database, please call HNC at (800) 990-5557.

Revised February 6, 2018