HEMOPHILIA of South Carolina
SERVING ALL BLEEDING DISORDERS

Financial Assistance and Financial Aid Fund Application Form

Please Print Clearly:

Personal Information Section

1. Applicants Name:_____

   Address: _____

   City: _____ State: _____ Zip: _____

   E-mail: _____ Phone 1: (C) _____
   Phone 2: (H) _____

   Date of Birth: _____

   Parent / Guardian Name (If Minor): _____

Financial need is being requested for?

_____
_____
_____

⟹ Medical Alert ID ○

Financial Need Requested: $_____

This request will be forwarded to the Financial Assistance Committee of Hemophilia of South Carolina. In the interest of privacy, identifying information will be removed from the request and forwarded to a blinded committee for review. Additional information may be required. All payments will be made directly to the party that is owed the monies. Please attach all supporting information including copies of bills and payment page. Applicants will be informed of the outcome of the committee review.

To the best of my knowledge, I hereby certify that the above information is correct and accurate.

_____**Date**:_____
Applicant (or parent/guardian

Approved _____Denied_____ Referred to HFA_____

Date: _____

Reason for denial (if applicable)

_____
_____
_____
_____

Section 2 – Blinded Information for Submittal

The applicant is:

_____ An adult with a bleeding disorder
_____ A caretaker of someone with a bleeding disorder living in your household
_____ A parent of a minor child with a bleeding disorder. Please include the age of the child with the bleeding disorder (_____) years.
_____Other, please explain_____

How many family members in your household?

Adults: _____Children (Under 18) _____

Did someone refer you to the HSC Financial Aid Program? Yes _____No_____
If referred, who is making the referral services? _____

Have you applied for assistance from any other sources, and if so, what is the status of that application?

_____
_____

What is the applicant's annual household income?

_____ Unemployed
_____ Less than $15,000
_____ $16,000 - $35,000
_____ $36,000 - $50,000
_____ $51,000 or greater

Employer: _____

Address of Employer _____

Phone Number of Employer _____

Creditor: Please supply the business or individual whom HSC should make payment:

Name: _____
Complete Address: _____
Account / Invoice Number: _____

HTC and Physician:

_____**Phone Number**_____

Have you applied for assistance from HSC in the past year? If so, please provide date:

_____

Please mail or fax in the application to:

Hemophilia of South Carolina, Attn: Financial Assistance Program

(See address information in the footnote section)