FLORIDA HEMOPHILIA ASSOCIATION

for all bleeding disorders

Compassionate Care Program
Financial Assistance Program Guidelines

Purpose:

The Florida Hemophilia Association's (FHA) Compassionate Care financial assistance program is part of FHA's continuing effort to improve the quality of life of individuals and families affected by bleeding disorders. This program provides funds to eligible individuals and families who need assistance with:

- Expenses incurred in the care, treatment, or prevention of a bleeding disorder, and/or
- Basic living expenses or emergencies.

Note: This program is intended to help individuals and families who have exhausted all other sources of assistance and for whom no other funds are available.

Eligibility:

To be eligible for this program you must meet the following criteria:

- You must be a resident of Florida AND provide a letter from your treatment center, hematologist or provider verifying that you receive treatment for a bleeding disorder.
- You must be the parent or caregiver of a child/minor who lives in your home and has a diagnosis of a bleeding disorder; OR be an individual with a diagnosis of a bleeding disorder.
- You must complete all sections of the application thoroughly and accurately.

Administration:

- Financial assistance depends on the availability of funds and applicant eligibility. Funding is not guaranteed. Applicants should allow at least two weeks for FHA to process their request.
- Assistance is limited to one grant per calendar year and a maximum of $500. In the presence of special circumstances, the FHA Board of Directors will review exceptional requests.
- Disbursements will be made only to creditors identified in the application and that have been verified by FHA. No payments will be made directly to applicants with the exceptions of gift card for groceries and or other approved items.

Request Process:

1. Requestor must provide the following:
   a. Formal letter of need, including an explanation of the situation and all contact information
   b. Letter from treatment center, hematologist, or provider verifying treatment for a bleeding disorder
   c. Copy of bill or invoice for which payment is requested
2. Completed applications must be submitted by email to padair@floridahemophilia.org or by Fax to (954) 900-5149.

3. The FHA staff will review applications for completeness and consider the date the funds are needed in order to determine the urgency of the request.
4. Incomplete applications will be returned to the applicant with an explanation of why it was returned and a description of the information still required.
5. Complete applications will be sent to the FHA committee for review.
6. If the application is approved, FHA staff will notify the applicant, and a check will be mailed to the creditor identified on the application.
7. If the application is rejected, FHA staff will notify the applicant with an explanation.

Confidentiality:

- Applications and information pertaining to funding requests are considered confidential.
- Information from FHA Compassionate Care financial assistance program applications may be compiled for statistical purposes, and for compliance with local, state, federal or affiliate organization requirements. However, any publication of this data will be in aggregate form only and will not include names or any other information that could be used to identify individual applicants or recipients.
- No personal information will be used or disclosed for any purpose other than that for which it was collected. At no time will personal information be shared with any individual, company, or organization outside of the Florida Hemophilia Association.

Patient Assistance Program Application

Applicant Name:____

Bleeding Disorder *(provide diagnosis and severity)*:____________________________

Street Address:____

City:________________________ State:________ Zip Code:__________

Phone Number:____________________ Email Address:____________________

Assistance Needed For:________________________ Date Due:______________

Description of circumstances surrounding request and how funds will be used:________________

____

____

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____

Amount requested:____

Check payable to:____

Address/City/State/Zip:____________________________________

Contact Name:____

Phone number:____

Please include the following supporting documents

- Letter from HTC Nurse, Social Worker, or Other Provider describing the circumstances surrounding the request.
- Copy of Invoice that assistance is being requested for.
  - For rent assistance, please attach a copy of the Lease Agreement.

Please send completed application and supporting documents to FHA
Email: padair@floridahemophilia.org Fax: (954) 900-5149

Date received in office:____________ Amount Approved:________________

Approved by:____

____

Date check sent:______________ Check Number:__________________