



NHF COLORADO FINANCIAL ASSISTANCE PROGRAM APPLICATION

Please review the NHF Colorado Financial Assistance Program guidelines and policy before submitting your application.

I have read and understand the Financial Assistance Program guidelines and policy. Initial here: _____

Completion of this application will automatically register you with the Colorado Chapter of the National Hemophilia Foundation and place you on the mailing list. If you do not wish to be placed on the mailing list, please initial here: _____

Complete the following information in a different font or color if filling out electronically. Sign, scan, and email or send via postal mail.

BASIC INFORMATION

Today's Date:

Applicant's First and Last Name: (Parent's names in case of a minor.)

Address (Street, City, State, and Zip):

Phone number(s) (where you can be reached for follow up questions):

Number of people living in the household:

Household income: (indicated per week, month, or year)

Number of persons receiving income:

Type(s) of medical insurance?

Do you have Medicaid?

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Employer(s):

Marital status:

Spouse's name:

Is spouse employed? If so, by whom?

The applicant is:

- Person with a bleeding disorder
- Parent of a minor child with a bleeding disorder
- Other: Please describe _____

Type of bleeding disorder:

FINANCIAL ASSISTANCE REQUEST

Please describe your need for financial assistance:

Use as much detail as possible.

Describe how assistance will help resolve the current need:

Include as much detail as possible.

Please list any additional financial assistance requested for the current needs, dates, and outcomes of each request:

This is not required, but is recommended.

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Amount requested (up to \$500):

NHF Colorado is able to provide a maximum of \$500 funding per person/family per year.

When are these funds needed?

Please be aware that NHF Colorado may need up to two weeks to process a request.

Have you applied for financial assistance from NHF Colorado (formerly HSC) in the past? If so, please provide the month and year.

NHF Colorado cannot provide funding directly to individuals, but if approved, NHF Colorado will pay to vendor directly. Please list your bill payment information below and include copies of bills with contact information wherever possible. Please review the Financial Assistance Program guidelines and policy for more information.

Bill Payment Request #1

Company Name/Establishment:

Account number:

Mailing address (address, city, state, zip):

Phone:

Website (when available):

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Bill Payment Request #2

Company Name/Establishment:

Account number:

Mailing address (address, city, state, zip):

Phone:

Website (when available):

Bill Payment Request #3

Company Name/Establishment:

Account number:

Mailing address (address, city, state, zip):

Phone:

Website (when available):

I, _____, certify that the information I have submitted is true and accurate to the best of my knowledge. In the event that there is a monthly income increase or decrease of more than 10% as reported on this application, I will notify the Colorado Chapter of the National Hemophilia Foundation within 30 days.

Signature:

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Please submit via email to info@cohemo.org OR via mail to:

National Hemophilia Foundation, Colorado Chapter*
1536 Wynkoop Street, Box26
Denver, CO 80202

**We CANNOT accept FedEx or UPS packages at this address.*

DO NOT WRITE BELOW THIS LINE

**To be completed by NHF Colorado Financial Assistance Committee or Board
Members Only**

Request approved by:

Amount approved:

Check number:

Date fund assistance mailed:

Sent by:

Sent to:

Address (address, city, state, zip):

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