CENTRAL CALIFORNIA BLEEDING DISORDERS FOUNDATION

EMERGENCY ASSISTANCE REQUEST

Full Name:

_____

Address:

_____

City, State, Zip:

_____

Email:

_____

Phone Number:

_____

Are you an active member of the Central California Bleeding Disorders Foundation? (An active member is defined as an individual who is in the CCBDF database and is an adult with a bleeding disorder or a parent or caregiver of a minor child who lives in your home and who has a diagnosis of a bleeding disorder OR be an individual with a diagnosed bleeding disorder.)

- ☐ **YES**
- ☐ **NO**
- ☐ **I have provided a copy of the patient referral form to this application**

What is the amount of your Emergency Assistance Request? _____

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What is the reason for your Emergency Assistance request? (Please note, this response should include what your request is and a short narrative as to why you are looking for assistance. You may be asked to provide more detail by the committee.)

_____
_____
_____
_____
_____
_____
_____

Have you applied for emergency assistance before? When was the application?

_____

When do you need the Emergency Assistance paid? (Please note that we ask for emergency assistance requests to be made 14 days in advance.)

_____

Signature: _____ **Date:** _____

Please attach to this application:
Documentation of Bill/Bills Due *
Patient Referral Form (If Required)
Any additional items you would like the committee to consider