In order to submit this form, you should open it with Adobe Acrobat Reader.

HTC Social Worker Financial Assistance Program Referral Application

Please complete the application form. A member of the HFM staff will review your referral and contact you within five business days. If you have any questions, please reach out to Dana Brendecke-Carrier at dbrendeckecarrier@hfmich.org.

Please complete your assessment and gather the supporting documents before submitting the referral.
Please read the financial assistance program eligibility guidelines carefully before completing the application:

- Patient must be a Michigan resident
- Patient must live in the home
- Bleeding disorder must be confirmed by HTC staff or other health care professional
- Applicant may apply once within a 12 month time period (special circumstances will be reviewed on a case by case basis).
- Referrer must have patient (caregiver if patient under 18) written permission to complete the application and Written permission to allow HFM to contact any vendors and make any payments on their behalf if approved.
- Referrer must submit clear copy of both sides of any bills that are submitted

*All approved payments are made directly to the vendor and not to individuals or applicants.

Has the patient or family received financial assistance from the Hemophilia Foundation of Michigan in the past 12 months? *

No
Yes
Unsure
Yes, case was reviewed and a 2nd application can be submitted

Patient/family may only apply for assistance once within a 12 month period. If the patient has already received assistance and are in need of additional support, please contact Dana Brendecke-Carrier to discuss the patient's needs.
Dana Brendecke-Carrier
dbrendeckecarrier@hfmich.org
734.544.0015

Name of individual filling out application *

Last Name

First Name

Patient Name *

First Name Last Name

Is the patient over the age of 18? *

Yes
No

Care Partner Name if Submitting the Application on Behalf of Patient

First Name Last Name

Caregiver Name *

First Name Last Name

Patient Address *

Street Address

Street Address Line 2

City State / Province

Postal / Zip Code

Does the person with the bleeding disorder reside at this address? (The individual must live at the address where the bill is sent.) *

Yes
No

The care partner (if the patient is over 18) or caregiver (if the patient is under 18) and the patient must reside at the same address to be eligible for financial assistance.

For questions contact Dana Brendecke-Carrier
Dana Brendecke-Carrier
dbrendeckecarrier@hfmich.org

734.544.0015

Patient/Care partner/Cargiver Phone Number *

Please enter a valid phone number.

Select ALL that apply: (please get the applicant's permission)

Yes, you can text the applicant at this number
Yes, you can leave a message for the applicant this number

Patient/Care partner/Caregiver Email

example@example.com

How many people live in the patient's home (HFM uses this information to better understand the number of community members we are able to assist)? *

What is the patient's bleeding disorder (If multiple family members have a bleeding disorder, you only need to list one to be eligible to apply)? *

Which Hemophilia Treatment Center (HTC) does the patient attend for care? *

Bronson Hemophilia Treatment Center, Kalamazoo
Helen DeVos Children's Hospital, Grand Rapids
Children's Hospital of Michigan, Detroit
Henry Ford Hospital, Detroit
Detroit Receiving, Detroit
Hurley Medical Center, Flint
Michigan State University, East Lansing
University of Michigan, Ann Arbor
Northern Regional Bleeding Disorder Center at Munson Medical Center, Traverse City
Non HTC hematology professional

Please ensure that the patient or care partner provides consent for the items below. If consent is not given, please work with the HFM social worker to determine how support can be provided. In some cases, if consent is withheld (e.g., for payment to a vendor), assistance may not be able to be provided. *

Does the patient (caregiver if patient under 18) give HFM permission to make a payment directly to the vendor if the financial assistance application is approved?

Does the patient (caregiver if patient under 18) give HFM permission to contact the organization that you are applying for assistance with?

Does patient (care partner if patient is under the age of 18) give the HFM permission to contact the Hemophilia Treatment Center/Non-HTC

hematology office to confirm the patient's bleeding disorder and partner with the HTC on the financial assistance application if necessary?

Please initial below indicating that you asked for consent for each individual checkbox: *

What is the amount of financial assistance the patient, care partner, or caregiver is requesting? Please note that requesting an amount does not guarantee that this is the amount we will be able to provide. *

Please briefly describe the financial assistance needed, including the name of the vendor. *

Upload a copy of the documentation to support the application. This is any document that will be needed to complete the application—for example a copy of the lease for rent assistance or the bill that patient/care partner is requesting assistance with.
***Please make sure that the copy is legible and includes both sides of the statement. If it is a screen shot the patient/care partner's name, address, account number, and breakdown of what is due is required.**
If you cannot upload a copy please email a copy to dbrendeckecarrier@hfmich.org.

If the request is for rent or other items payment please include the landlord/vendor name and contact information here:

Please note that completion of this application does not guarantee approval of the financial assistance request. We strive to provide support and resources to the bleeding disorders community but in some cases we are unable to assist.