EMERGENCY ASSISTANCE GRANT PROGRAM

Eligibility Requirements:

*Must be a parent or guardian of a minor child who lives in your home and who has a diagnosis of a chronic inherited bleeding disorder OR be an individual with a diagnosis of a chronic inherited bleeding disorder.

*Must be a United States citizen or legally living permanently in the United States

*Must have an emergency financial need of $750 or less. Acceptable requests are:

- Utility bill
- Medical bill
- Auto repairs
- Home repairs
- Emergency transportation services due to bleeding disorder
- Other expense deemed appropriate by the Colburn-Keenan Foundation, Inc. (CKF)

*No one in the household must have received an Emergency Assistance Grant or Individual Assistance Grant from CKF over the past 365 days.

*The attached application, financial statement & medical verification must be completed in their entirety and returned along with a copy of the invoice you are requesting assistance with.

Additional Information:

*Emergency financial assistance is limited to a maximum award amount of $750 per application. Any household that has received an Emergency Assistance Grant for three consecutive years, will be ineligible for one year.

*If after receiving this grant you find yourself in additional financial need, you MAY apply to the Individual Assistance Grant Program that CKF offers, but will need to supply a statement as to why you applied to both within a 365 day period.

*Submission of an Application, does NOT guarantee an award. Applications for emergency financial need will be reviewed and either approved or denied by CKF and is dependent on the availability of funds. All decisions are final.

*CKF does not provide funding directly to the applicant. Any award payment will be mailed directly to the vendor with a copy of the payment letter being mailed to the applicant. CKF is not responsible for any account that defaults due to late payment and is also not responsible for any cancellation of service or coverage.

P.O. Box 811, Enfield, CT 06083 Tel 800-966-2431 Fax 888-345-0259 admin@colkeen.org www.colkeen.org

EMERGENCY ASSISTANCE GRANT PROGRAM APPLICATION

Our Emergency Assistance Grant Program, provides emergency assistance to individuals and families who are United States citizens or legally living permanently in the United States and who are affected by chronic inherited bleeding disorders.

Instructions:

1. Do not leave any line of the application of financial statement blank. Write "N/A" if not applicable.
2. Please print clearly & use dark ink.
3. Sign & date pages 3 **AND** 4.
4. Obtain a signed medical verification form (must use our form found on page 5)
5. Email, fax or mail your application, financial statement, medical verification form and copy of the invoice you are requesting assistance with. The copy of the invoice must be in its entirety with payment coupon attached (if applicable). Screen shots of your account will not be accepted.

If you have any questions while completing the application, please call.

Applicant Information	
Full Name (first, middle initial, last):	
Date of Birth:	
Address:	
City, State & Zip:	
Home Phone:	
Cell Phone:	
Email:	
Other Individuals in the Same Household (not including yourself)	
How many adults (ages 18+) reside in the household?	
How many children (under 18) reside in the household?	
Diagnosis Information	
Full Name (first, middle initial, last) of the individual in the household with the bleeding disorder:	
What is the diagnosed bleeding disorder?	
Date of Birth:	
Relationship to the Applicant:	

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Request	
What invoice(s) are you requesting assistance for?	
Is this a one-time expense or monthly expense?	
If a monthly expense, what are you doing to ensure that this bill will be paid next month?	
What is the amount you are requesting?	
If the amount due is over $750, how will you pay the difference?	
When is payment due?	
Have you applied to any other organization for assistance for this particular invoice?	
If yes, what decision did they make?	

Brief description of circumstances leading to this financial hardship:

_____

_____

_____

I confirm that the information provided on this application form and in all supporting documentation is complete and accurate. I understand that grant assistance is not guaranteed. I understand that, if my grant request is approved, payments will be sent directly to the vendor to which they are due. I understand that it is my responsibility to ensure that my accounts do not default due to the grant payment not being able to be sent out ahead of the due date. The Colburn-Keenan Foundation, Inc. is not responsible for any cancellation of service or coverage. If approved, I agree to promptly return to the Colburn-Keenan Foundation, Inc. any refund check from a company due to overpayment resulting from grant funds.

By signing, I attest that I have read the above and agree to abide by the policies of the Emergency Assistance Grant program as outlined in this application and through all other correspondence with the Colburn-Keenan Foundation, Inc. I attest that I am a United States citizen or legally living permanently in the United States.

Applicant's Signature:_____ Date: _____

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EMERGENCY ASSISTANCE GRANT PROGRAM FINANCIAL STATEMENT

I, _____ (Applicant's Full Name), hereby declare that I am not able to meet my financial responsibilities for the requested invoice. I am applying for a one-time emergency assistance grant through the Colburn-Keenan Foundation, Inc. in the amount of $_____ (not to exceed $750). I submit the following financial statement:

Monthly Net Household Income (include employment, self-employment, unemployment benefits, social security, disability benefits, child support and alimony, etc.)

Applicant:	$
Spouse/Partner:	$
Additional Household Member:	$
Additional Household Member:	$
Additional Household Member:	$
TOTAL NET MONTHLY INCOME	**$**

Monthly Food Stamps:_____
Monthly Public Assistance (what & how much):_____

Monthly Household Expenses:

Mortgage/rent	$
Homeowner's Insurance	$
Property Taxes (if not escrowed in mortgage)	$
Utilities (electric, heat, etc.)	$
Cable and/or internet	$
Home Phone	$
Cell Phone	$
Medical Insurance (if not a deduction out of pay)	$
Auto Loan #1	$
Auto Loan #2	$
Auto Insurance	$
Gas for Auto	$
Public transportation Expenses	$
Education Expenses	$
Childcare Expenses	$
Groceries/Food	$
Addt'l Expense:	$
Addt'l Expense:	$
Addt'l Expense:	$
TOTAL MONTHLY EXPENSES:	**$**

By signing, I certify that the financial information I have provided above is true and accurate.

Applicant's Signature:_____ Date:_____

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CK Colburn Keenan Foundation, Inc.

EMERGENCY ASSISTANCE GRANT PROGRAM

The applicant listed below has indicated that you are their treating physician or their child's treating physician. Please complete and return this signed form to the applicant so they can submit it with their application.

Applicant Name:_____

Patient's Name and Date of Birth:_____

PHYSICIAN INFORMATION

Full Name: _____

Address: _____

_____

_____

Phone: _____

BLEEDING DISORDER DIAGNOSIS *(please check all that apply, including severity)*

_____ Hemophilia A
_____ Hemophilia B
_____ Factor VII Deficient
_____ Other Factor Deficiency

_____ Von Willebrand Disease

_____ Severe
_____ Moderate
_____ Mild
_____ Inhibitor

_____ Type 1
_____ Type 2
_____ Type 3

Other inherited bleeding disorder *(please explain, including typical symptoms/complications and the degree to which the disorder affects the applicant's quality of life)*

_____

_____

_____

_____

_____

Physician's Signature: _____

[please include your stamp or seal at the bottom of this page]

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