Bleeding Disorders Association
of Northeastern New York, Inc.

333 Broadway, Suite 320
Troy, NY 12180
Phone: 518-729-3577
memberservices@bdaneny.org
www.BDANENY.org

Application for Member Support

Please Read and Complete:

PLEASE PRINT

This policy was established to assist people in the bleeding disorders community during times of financial hardship. Each application will be reviewed by the members of the Board of Directors of the Bleeding Disorders Association of Northeastern New York, Inc. (BDANENY). **Applicants should allow 14 business days for the BDANENY to process.**

Name: _____

Telephone: (primary): _____ (secondary): _____

Address: Street: _____ Apartment: _____

City: _____ State: _____Zip: _____ Email: _____

Reason for funding request. Please provide pertinent information (i.e. receipts of bills). Attach additional documentation if needed.

_____

_____

_____

_____

The organization shall award member support in an amount not to exceed $500.00 with a yearly maximum of $750.00.

Amount Requested: _____

An Affiliate of the National Hemophilia Foundation
An Affiliate of the Hemophilia Federation of America

Certification

Notice: This application will be kept strictly confidential.

I certify that I am a consumer of the bleeding disorders community and that everything in this application is true.

Signature: _____

Date: _____/_____/_____

Per Policy, member support will be provided directly to creditors on your behalf when possible.

DO NOT WRITE BELOW THIS LINE (For office only)

Date application received: _____/_____/_____

Recipient's Initials: _____

Approved: _____ Date: _____/_____/_____

Disapproved: _____ Date: _____/_____/_____

Reason:

_____

_____

_____

Additional Information Requested: Date: _____/_____/_____

_____

_____

_____

Has member applied for Member Support within the past twelve months?

Yes _____ No _____

If so, when: _____

Revised: July 19, 2006
March 31, 2011
Dec 2015