BLEEDING DISORDER FOUNDATION OF WASHINGTON
EMERGENCY ASSISTANCE REQUEST

APPLICANT INFORMATION		
Name:		
Date of birth:		Phone:
Current address:		
City:	State:	ZIP Code:
Email:	Amount Requested:	Date Needed:

REASON FOR THIS REQUEST

ADDITIONAL AGENCIES OR SOURCES OF FUNDS TO WHOM YOU HAVE APPLIED FOR AID

Name:	Phone:	Status:
Name:	Phone:	
Name:	Phone:	Status:

CREDITOR – THE BUSINESS TO WHOM THE BDFW SHOULD SEND THE CHECK:

Name:

Address:	State:	Zip Code:
Phone:	Amount:	Account #:

THE APPLICANT IS:

____ Person with bleeding disorder ____Parent of a minor child with a bleeding disorder

____ Other (please describe relationship)

Type of bleeding disorder:

EMPLOYMENT INFORMATION		
Current employer:		
Employer address:		How long?
Phone:	E-mail:	Fax:
City:	State:	ZIP Code:
Position:	Hourly Salary *(Please circle)*	Annual income:

SPOUSE INFORMATION
Name:

SPOUSE EMPLOYMENT INFORMATION	
Current employer:	
Employer address:	How long?

BLEEDING DISORDER FOUNDATION OF WASHINGTON EMERGENCY ASSISTANCE REQUEST 		
City:	State:	ZIP Code:
Phone:	E-mail:	Fax:
Position:	Hourly Salary *(Please circle)*	Annual income:
PERSONAL REFERENCES		
Name:	Address:	Phone:
Name:	Address:	Phone:
HAVE YOU APPLIED FOR ASSISTANCE FROM THE BDFW IN THE PAST?		
______No	____Yes When: (Month/Year)	
SIGNATURES		
I authorize the verification of the information provided on this form as to my credit and employment. I have received a copy of this application.		
Signature of applicant:		Date:

Please note: That the Bleeding Disorder Foundation of Washington (BDFW) will make only one grant in aid to an individual or family per year. Grants are never made directly to an individual. Payment is only made to a creditor that can be verified by BDFW. Each request is submitted to the Emergency Assistance Committee for review and then the BDFW Board of Director for Approval. Funds available through this program are limited and are provided on a first-come, first-served basis until monies are exhausted for that calendar year. Due to limited resources BDFW does not make grants in excess of $300.

Personal information will not be used or disclosed for purposes other than those for which it was collected. At no time is private information shared with any individual, company or organization outside of BDFW.

__ Please check here if you prefer not to be added to the BDFW database.

Return this form, along with a **copy of the bill** for which you are requesting assistance to:

Bleeding Disorder Foundation of Washington
9659 Firdale Avenue
Edmonds, WA 98020

Or Fax to: (206)533-1686

Questions? Call BDFW at (206)533-1660