



Financial Assistance Request Form

Please submit this form to either your clinic representative to submit on your behalf, or directly to the Manager of Member Services and Support at Hemophilia Ontario at: 10 Milner Business Court, Suite #300, Scarborough, Ontario, M1B 3C6

Name: _____ Apartment/Suite: _____
Email: _____ Postal Code: _____
Address: _____ Home Telephone: _____
City: _____ Cell/Alternate Number: _____
Type of Bleeding Disorder: _____ Treatment Center: _____

Details of Request (Please include reasons for the request and if you prefer electronic transfer or mailed cheque):

For financial support, please check off one or more of the following options below:

Hotel Accommodation Transportation (Appointments) Other, please provide more detail:
 Hospital Parking Medication _____
 Dental Assistive Devices/Equipment _____

Member Signature: _____ **Date:** _____ **Amount Requested: \$** _____

(Hemophilia Ontario and its Regions adheres to prevailing privacy legislation. Any information about you as an identifiable individual, including your name, an identifying number such as your birth date, your email address, or your credit card information will not be provided to a third party. Hemophilia Ontario reserves the right to contact medical personnel for additional information as necessary when considering submitted requests.)

For Office Use Only

Executive Director Signature: _____ **Amount Supported: \$** _____ **Date:** _____