

LHF HEMOPHILIA DISASTER RELIEF FUND APPLICATION

Organization _____ DISASTER: _____

TODAY'S DATE: _____

Date Mailed to Vendor: _____

Medical Care Provider? _____

Have you contacted them: _____

NAME OF APPLICANT: _____

Family Members and Ages: _____

Name of Person w/bldg disorder: _____

Type of Bleeding Disorder: _____

ADDRESS AT THE TIME OF DISASTER:

Address: _____

Phone: _____

Do you plan to return to LA?: _____ If so, where?: _____

PRESENT ADDRESS:

Address: _____

Phone: _____ Cell: _____

Living Arrangements:	Long Term: _____	Short Term: _____
Shelter: _____	Relative: _____	New Permanent Residence: _____
Additional Aid: _____	(dollar amt)	
FEMA: _____	SSI/SSDI: _____	UNEMP: _____
	Food Stamps: _____	Private Ins: _____
OTHER - Explanation: _____	Have you found employment: _____	

Immediate Need: _____

Long Term Need: _____

Payable To: _____ **Amt:** _____

Address: _____

Account Number: _____

ASSISTED WITH (to be completed by LHF)

Bill _____

Gift Card _____ Amt: _____ Where to: _____

In Kind: (description) _____

Other: (description) _____