

Please read these brief instructions. Application form begins on next page.

B-Cares—the Coalition for Hemophilia B's emergency assistance fund—provides urgent help to individuals or families affected by hemophilia B when faced with specific critical needs. These crisis situations may include housing, transportation, and utility bills. B-Cares cannot cover any medical expenses including medical bills, dental bills, insurance premiums, co-payments, deductibles, and medications including clotting factor.

ELIGIBILITY CRITERIA

- Applicants **must have a diagnosis of hemophilia B and/or be immediate family members** in the same home.
- The person with the diagnosis **must be under the care of an appropriate medical care provider.**
- Applicants **must be able to explain a hardship** they currently or recently experienced.
- Applicants **must submit proof of total family income and budget** and provide copies of each bill they are requesting assistance for.
- Applicants **must provide a medical note stating why can't they work** and a copies of ER visits/medical bills to validate that they are under care of an appropriate medical provider.

REVIEW PROCESS

Completed applications are reviewed once monthly by a committee that will decide on assistance based on the urgency of the need and currently available funds. New patient priority requests will take precedence over those who have received funding in the past.

All information will be kept confidential. Each request will be reviewed on a case-by-case basis. There is no guarantee that any particular request will receive funding.

This Patient Assistance application form can be completed electronically and returned by email (with requested documentation as email attachments). Return the completed application form to FarrahM@hemob.org. You can also print the form, fill it out, and submit the completed form by fax to 212-520-8501 or by mail to Kim Phelan, 757 Third Avenue, 20th Floor, New York, NY 10017.

Questions? Email FarrahM@hemob.org or call 212-520-8272.

Continue to page 2 to begin the application.



THE COALITION FOR HEMOPHILIA B, INC.

B-CARES PATIENT ASSISTANCE FORM

1. PATIENT INFORMATION

Patient Name: _____ Date of Birth: _____

Patient Address: _____

Email: _____ Mobile#: _____

If someone other than patient completes the form please provide name and relationship to patient:

_____/_____
NAME RELATIONSHIP TO PATIENT

2. MEDICAL INFORMATION

Patient Diagnosis: _____ Date of Diagnosis: _____

Patient Insurance Carrier: _____

Patient Current Medications: _____

**Please attach a medical note from the patient's primary doctor
stating the number of days taken off from work or the reason the patient can't work.**

3. YOUR REQUEST INFORMATION

Reason for assistance:

Please list the specific bills you need assistance for:

Please attach copies of each bill that you are requesting assistance for.

Please attach a separate letter stating what the funding will be applied to.



THE COALITION FOR HEMOPHILIA B, INC.

4. FINANCIAL INFORMATION

Monthly Income of Household (households include everyone living in the home): _____

Please put a checkmark (✓) to indicate if you receive any of the following:

Child Support ☐ Social Security ☐ Welfare ☐ Food Stamps ☐ Rental Assistance ☐

Please list any other sources of income you have received in the last 6 months

5. DOCUMENTS REQUIRED TO SUBMIT REQUEST

Please attach at least one (1) of the following to show need:

- Latest W2 form
- Latest two (2) months of paystubs
- Termination of Employment Letter

Additionally:

- Please attach any letters, bills or documentation reflecting the amounts you are requesting.
- Please attach medical note stating why you can't work; copy of ER visit/medical bills.

6. ADDITIONAL QUESTIONS

Have you received help from your local chapter, HFA or Hope for Hemophilia or any other patient assistance programs in the past 12 months? _____

If yes, what was the outcome? _____

BEFORE SUBMITTING YOUR REQUEST:

Please review your application form. All 6 sections must be completed to be submitted for approval. Any missing or incomplete information will automatically cause the form to be returned until completed.

Requests are reviewed once monthly and we currently have a waiting list. All requests are approved on a priority basis. New patient priority requests take precedence over those who have received funding in the past. Each request is reviewed on a case-by-case basis.

KINDLY SUBMIT ALL DOCUMENTS AS FOLLOWS:

By email to: farrahm@hemob.org. Supporting documents (e.g., W2, copies of bills, medical note, etc.) may be scanned and submitted as email attachments.

By fax to: 212-520-8501, attention Farrah Muratovic, Patient Liaison

By regular mail to: Kim Phelan, The Coalition for Hemophilia B, 757 Third Avenue, 20th Floor, New York, NY 10017.

Thank you. Board of Directors, Coalition for Hemophilia B