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4976 Eichelberger Street  
St. Louis, MO 63109

Phone: (314) 482-5973 Email: [info@gatewayhemophilia.org](mailto:info@gatewayhemophilia.org)

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## **HELPING HANDS**

### **Mission Statement**

The Helping Hands Program exists for the sole purpose of providing emergency financial assistance to those persons who have been physically, emotionally, and financially affected by a bleeding disorder.

### **Program Goals**

Through grants, fundraising and direct gifts this program aims:

- Address quality of life issues
- Assist in emergency crisis situations deemed reasonably by the Committee
- Ensure that the application and assistance process is both minimally invasive and confidential

### **Application Process**

Once a referral is received, the Helping Hands Coordinator contacts the applicant within 24-36 hours to complete a phone interview. Each applicant is asked a standard set of questions about monthly household income, expenses, and the situation causing the current need. The application is then submitted to the Helping Hands Committee who gives each applicant careful consideration in his/her personal circumstances while ensuring a minimum invasion of privacy. The applicant's identity is not shared with the committee. If approved, the applicant is required to submit a written statement of need along with proof of the emergency or urgent situation prior to payment.

### **Program Criteria**

- Persons with a bleeding disorder, or a person financially dependent on the head of household of a person with a bleeding disorder
- Living within the geographical service area of GHA
- Must be a member of Gateway Hemophilia Association
- Funding shall not exceed \$500 per calendar year per household
- Amount approved may be based on availability of funds
- Persons making the request must provide copies of bills or invoices or other documentation regarding the request. Funds will only be released for a specific, known emergency need.
- Applicants are eligible to apply for funds every other year or ONCE every 731 days. For example, a person who most recently applied for assistance in January 2016 will be eligible to apply for funds in January 2018.
- Provide funding for emergency crisis and/or other medically necessary services or situations, related to the individual's or family member's bleeding disorder
- The applicant must have a referral to the Helping Hands Program Coordinator from a Helping Hands Eligible Referrer, \*\*which could be from one of the following:
  - a.) Physician, Nurse, or Social Worker from a Hemophilia Treatment Center
  - b.) Private Physician
  - c.) Representative from a National, Regional, State, or Local Bleeding Disorder Organization
  - d.) Homecare Representative of the Applicant

The Committee will not base decision on the basis of race, color, gender, religion, national origin, age, disability, sexual orientation, or any other legally protected characteristics.

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Visit our Web Site at [www.gatewayhemophilia.org](http://www.gatewayhemophilia.org)

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### Helping Hands Application

Application #	Date	Application completed by		
Last Name		First Name	Primary Phone #	Last 4 digits of SSN
Address		City	State	Zip
Applicant's DOB				
Amount Requested	Describe Situation/Reason and Basis for Need			
Do you have a Division of Family Services or Social Worker working with you? Yes <input type="checkbox"/> NO <input type="checkbox"/>				
If yes, name and phone number				
GHA's assistance program should be considered a last option. What other resources have you contacted (i.e. parish, church, local organizations)?				
How long has this problem existed? Have you filed a letter of medical necessity with your local utilities?				
Name of Payee		Account #	Payee Phone #	
Amount Necessary for Continued Services		Date Payment Required	Notes- include a copy of utility bill if applicable	
Additional Resources		Phone	Action	

I \_\_\_\_\_, verify the above information to be true and accept action taken by the Gateway Hemophilia Association on my behalf. I will respond to recommendations provided to me within thirty (30) days after payment is made.

Signature \_\_\_\_\_ Date \_\_\_\_\_

**GHA Office Use Only**

<input type="checkbox"/> Disapproved	<input type="checkbox"/> Approved	Check #	Amount \$	Date payment mailed
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