GATEWAY HEMOPHILIA ASSOCIATION

4976 Eichelberger Street
St. Louis, MO 63109

Phone: (314) 482-5973 **Email:** info@gatewayhemophilia.org

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 2020 will be eligible to apply for funds in January 2022.
- 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. No cash is given and no payment is ever made directly to applicant.

GATEWAY HEMOPHILIA ASSOCIATION

4976 Eichelberger Street
St. Louis, MO 63109

Phone: (314) 482-5973 **Email:** info@gatewayhemophilia.org

Helping Hands Application

Application# (office use)	Date	Application completed by	
Last Name	First Name	Primary Phone #	Bleeding Disorder
		( )	
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 ☐ NO ☐

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?

Yes ☐ NO ☐

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

Contact	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

☐ Disapproved	☐ Approved	Check #	Amount $	Date payment mailed