# Hemophilia Alliance Foundation

# 2017 Application

1. State applicant organization type: Local Chapter, HTC, Regional Office, or National Organization.
2. Contact information
3. Name of applicant organization
4. Address
5. Name of contact person
6. Telephone of contact person
7. Email of contact person
8. Amount Requested

a. Amount for project\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_.

b. Amount For patient/consumer assistance \_\_\_\_\_\_\_\_\_\_\_\_\_\_ .

c. For collaboration list partners, and how much is included for each.

1. Name, signature **and email address** of authorized Individual.
2. Organization description: **brief** description of mission, geographic service area, # served.
3. **Brief** description of the project and/or patient/consumer-financial assistance you propose. For patient/consumer-family financial assistance programs, attach your criteria or guidelines for awarding assistance.
4. **Brief** description of the need that the project addresses.
5. Concisely state the specific outcomes or measureable objectives of the project.
6. How will the project strengthen your organization?
7. Itemized Budget - Format

|  |  |
| --- | --- |
| **Item Description** | **$ Amount** |
|  |  |
|  |  |
|  |  |
| **TOTAL** |  |

**See Sample Budget in Appendix C**

**For submission requirements, deadline, filename requirements, required attachments, 2017 grant guidance.**