



THE NORTHERN OHIO  
**HEMOPHILIA**  
**FOUNDATION INC.**

Term of Membership: Membership expires **one year** from date received

Please mail your completed application with the appropriate membership level fee to:  
Northern Ohio Hemophilia Foundation, Inc. 5000 Rockside Rd., Suite #230 Independence, OH 44131

Please check one and follow matching color code throughout the application:

**CONSUMER APPLICANT:** I either have a bleeding disorder or am the partner of / parent of a minor child with a bleeding disorder.

**NON-COMSUMER APPLICANT:** I am a friend or extended family member of a person with a bleeding disorder (adult sibling, grandparent, aunt, uncle or cousin).

Please complete all sections. The information you provide will assist NOHF in planning programs to best meet member needs. This data is for the confidential use of NOHF only.

Adult # 1 Name: \_\_\_\_\_ E-mail address: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Home Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

Adult # 2 Name: \_\_\_\_\_ E-mail address: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Home Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

Family Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_ County: \_\_\_\_\_

**Household Members With a Bleeding Disorder:** PLEASE LIST ONLY FAMILY MEMBERS WHO LIVE IN YOUR HOME. Items with an asterisk (\*) are important for United Way reporting purposes and will not be used in any other way.

Name	Race*	Sex*	Date of Birth*	Type of Bleeding Disorder: (VIII, IX, VWD etc.)	Level/Type: (Mild, Moderate, Severe, 1, 2, 3)	Inhibitor? If unknown, leave blank	Product Used

**Other Household Members Without a Bleeding Disorder:** Please provide this information to assist NOHF with planning sibling and family programs.

Name	Relation	Race*	Sex*	Date of Birth *

Who is your treating physician/HTC? \_\_\_\_\_

Do you use a home healthcare agency? If yes, which one? \_\_\_\_\_

Annual Household Income - For United Way Reporting Purposes ONLY: (Please check appropriate range)

- \_\_\_ Less than \$5,000                      \_\_\_ \$5,000 - \$9,999                      \_\_\_ \$10,000 - \$14,999
- \_\_\_ \$15,000 - \$24,999                      \_\_\_ \$25,000 - \$34,999                      \_\_\_ \$35,000 - \$ 49,999
- \_\_\_ \$50,000 - \$74,999                      \_\_\_ \$75,000 - \$99,999                      \_\_\_ \$100,000 or more

Employers: If more than one adult is employed; please list both adult names and employers.

Adult # 1 Name \_\_\_\_\_ Adult # 1 Employer \_\_\_\_\_

Adult # 2 Name \_\_\_\_\_ Adult # 2 Employer \_\_\_\_\_

**Membership Levels - Consumers:** The consumer membership includes the Hemo-Link newsletter, camp scholarships, educational scholarships, MedicAlert membership and emblem, counseling payment assistance, emergency financial assistance, and invitations to educational, recreational and wellness programs.

- \_\_\_ \$0                      Hardship Membership: Person or family with bleeding disorder and financial hardship
- \_\_\_ \$15                      Single Membership: Individual with a bleeding disorder
- \_\_\_ \$25                      Family Membership: Immediate family / person with a bleeding disorder
- \_\_\_ \$                      Additional donation

**Membership Levels - Non-Consumers:** The non-consumer membership includes the Hemo-Link newsletter and priority notification for selected programs and special events. *Not all consumer programs are available free of charge to non-consumer members.*

- \_\_\_ \$25                      Bronze Friend
- \_\_\_ \$50                      Silver Friend
- \_\_\_ \$100+                      Gold Friend

**Please check relationship to person with a bleeding disorder:**

Friend                                       Family member / How are you related? \_\_\_\_\_

Name of person with bleeding disorder you have a relationship with: \_\_\_\_\_

The NOHF \_\_\_ may / \_\_\_ may not use photographs of my family in the newsletter or other materials.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

Your assistance is needed! Get involved with the following volunteer opportunities...

Please check all areas of interest:

- \_\_\_ Serve as a NOHF Board Member                      \_\_\_ Special Events Planning Committees
- \_\_\_ Local and/or National Advocacy Opportunities                      \_\_\_ Additional Volunteer Opportunities

For office use only:

Date received \_\_\_\_\_ Payment Type \_\_\_\_\_ Member ID \_\_\_\_\_ New Member? \_\_\_\_\_ Expiration Date \_\_\_\_\_