Patient Access To Healthcare Application

ALL SECTIONS MUST BE COMPLETED

Help Us Solve
The Cruel Mystery
LUPUS™
FOUNDATION OF AMERICA
TEXAS GULF COAST CHAPTER

Name: _____

Street: _____

City: _____ **State**: _____ **ZIP Code**: _____

Home Phone: _____ **Mobile**: _____

Email: _____@_____

Date of Birth: _____ **Marital Status**: _____

School (currently enrolled?): _____ **Yes** _____ **No**

School Name: _____

Type of lupus: _____ **Date of diagnosis**: _____

Insurance: _____ **Private** _____ **Medicare** _____ **Medicaid**

Are you receiving SSDI?: _____ **Yes** _____ **No**

Employment Status: _____

Monthly Household Income: _____
(Please provide proof of income in the forms of a pay stub and bank statement)

# of Household dependents: _____

PHYSICIAN INFORMATION

Physician Name: _____ **Phone**: _____

Street: _____ **Fax**: _____

City: _____ **State**: _____ **ZIP Code**: _____

AUTHORIZATION TO EXCHANGE INFORMATION

I, _____, hereby authorize the exchange of my medical information and any other pertinent information directly or indirectly related to my lupus condition between the Lupus Foundation of America, Texas Gulf Coast Chapter, Inc. and

_____.

(Physician/Hospital/Clinic/Pharmacy/Insurance Provider)

Patient's Signature: _____

Date: _____

Parent or Guardian Signature: _____
(if patient is under the age of 18)

Relationship: _____

STATEMENT OF NEED

Please describe the service or item that you are requesting AND provide a copy of any invoices if applicable:

_____

_____

_____

If you are approved for patient assistance, payment for services will be made directly to the service provider or vendor.

Signature: _____ **Date**: _____

Please mail or fax your application to:

Lupus Foundation of America, Texas Gulf Coast Chapter
405 Main Street Suite 300C
Houston, TX 77002
Phone: 713-529-0126 Toll-Free: 800-458-7870 Fax: 713-529-0780