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

2021 Patient Access to Healthcare Application

ALL SECTIONS MUST BE FILLED OUT

CLIENT INFORMATION:

Name:	Date of Birth:
Address:	Race:
City: State:	Zip:
Home Phone:	Mobile:
Email:	Marital Status:
Lupus Type:	Date of Diagnosis:
School (currently enrolled?) _____Yes ____No	School name:
Insurance: ___ Private ___Medicare ___Medicaid	Are you receiving S.S.I. Disability: ____Yes ____ No
Monthly Household Income: PLEASE PROVIDE PROOF OF INCOME-CHECK STUB & BANK STATEMENT	Employment Status: # of Household Dependents:
Have you ever been convicted of a felony? Yes__ No __ Are you a legal U.S. resident? Yes__ No__	Explain:

PHYSICIAN INFORMATION:

Physician's Name:	Phone:
Address:	Fax:

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: ________________________ Relationship: ____________
(If patient is under the age of 18 years)

Statement of Need: (Please describe the service, or service item that you are requesting AND provide copy if invoice if applicable)

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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
2503 Robinhood Street, Suite 275
Houston, TX 77005
Phone: 713-529-0126 or 800-458-7870 Fax: 713-529-0780