Help Us Solve
The Cruel Mystery
LUPUS
FOUNDATION OF AMERICA
UTAH CHAPTER

Dear Applicant,

Thank you for your interest in the Utah Chapter Medication Assistance Program (MAP). The Lupus Foundation of America, Utah Chapter, Inc., offers a Medication Assistance Program to help lupus patients pay for the high cost of medication. Doctors prescribe a vast array of medications to treat lupus that are critical to helping prevent complications, control current flares and treat the symptoms of lupus that can be different from one person to the next. Many of these drugs can be very expensive. Our goal is to help ease the burden that the cost of these medications can have on a person or family.

Enclosed you will find the MAP application and waiver of liability. All of the information you provide us is confidential and will not be shared without your written permission.

Once you have completed the MAP application and signed the waiver of responsibility, please mail them to the address below. You may also drop it off at the office.

Lupus Foundation of America, UT Chapter, Inc.
Attn: MAP Committee
352 S Denver St, #101
Salt Lake City, UT 84111

Upon receipt, your application will be reviewed in accordance with the MAP policies. Medication assistance will be awarded on a case-by-case basis in $100.00 increments. While we would like to fund every person in need, there is a limited amount of funds allocated for this program each fiscal year. Once all monies have been awarded, we will be unable to accept applications until the following fiscal year beginning October 1. We will review every application within 15 business days of receipt and inform you of our decision within this time frame.

If you have any questions, or need help with the application, please contact our office at 801-364-0366 or 1-800-657-6398 or by email at info@utahlupus.org.

Sincerely,

MAP Committee
Lupus Foundation of America, Utah Chapter, Inc.

Lupus Foundation of America, Utah Chapter, Inc.
Medication Assistance Program Application

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Personal Information

Name	
Street Address	
City ST ZIP Code	
Home Phone	
Work Phone or Cell Phone	
E-Mail Address	
Date of Birth	
Married/Single/Widowed	
Male or Female	
Social Security Number	
Do you receive Social Security Disability?*	
Do you have insurance or Medicaid or Medicare?*	
How many are in your household?	
What is your total monthly household income?*	
When were you diagnosed with lupus?	
Do you have a diagnosis other than lupus?	

*Please provide documentation of SSD, Medicaid, Medicare (if applicable), and income and attach to application

Medications

Please provide photocopy or pharmacy print out of the prescriptions for which you are requesting financial assistance

Medication & Dose	Cost	Medication & Dose	Cost

Additional Information

Please tell us any additional information about yourself or your circumstances that you would like us to know

Agreement and Signature

I certify that the cost of the medication(s) listed above is a hardship on my family. By signing this application, I certify that all information is accurate to the best of my knowledge. I understand that the LFA, Utah Chapter, Inc. has permission at any time to request verification of any information I provide.

Name (printed)	
Signature	
Date	

PHYSICIAN SIGNATURE

Please have your physician sign below or attach a letter confirming your diagnosis.

I certify that the patient listed on this application is receiving treatment for lupus.	
Physician Name (Printed)	
Physician Signature	
Date	
Address	
Phone Number	

Please submit completed application, any necessary documentation and Waiver of Responsibility to:
Lupus Foundation of America, Utah Chapter, Inc.
Attn: MAP Committee
352 D Denver St. #101
Salt Lake City, UT 84111

801-364-0366 / 1-800-657-6398
www.utahLUPUS.org / info@utahlupus.org

Our Policy

It is the policy of the Lupus Foundation of America, Utah Chapter, Inc. to provide equal opportunities without regard to race, color, religion, national origin, gender, sexual preference or age.

Thank you for completing this application and for your interest in this program.

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Waiver of Responsibility

By signing this waiver, I and anyone entitled to act on my behalf hereby waive and release the Lupus Foundation of America, Utah Chapter, Inc. and staff/ volunteers from all claims and liabilities related to prescription medication cost assistance provided to me.

I certify that I have read and understand the intent of this waiver and release.

Print Name _____

Phone number _____

Signature _____ Date _____
(Parent or legal guardian if applicant is under the age of 18)

This waiver must be completed and submitted for your application to be considered.

Thank you.

Please submit completed application and signed waiver to:

Lupus Foundation of America, Utah Chapter, Inc.
Attn: MAP Committee
352 S Denver St. #101
Salt Lake City, UT 84111