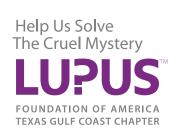
Patient Access To Healthcare Application





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 Medic	are Medicai	d	
Are you receiving SSDI?: Yes	_ No		
Employment Status:			
Monthly Household Income: (Please provide proof of income in the forms of a p			
# of Household dependents:			
PHYSICIAN INFORMATION			
Physician Name:		Phone:	
Street:		Fax:	
City:	State:	ZIP Code:	

AUTHORIZATION TO EXCHANGE INFORMATION

l,	, 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 Ameri	ca, Texas Gulf Coast Chapter, Inc. and
(Physician/Hospital/Clini	ic/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, paym	nent 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 Chapte
440 Louisiana St. Ste 900
Houston, TX 77002

Phone: 713-529-0126

Toll-Free: 800-458-7870 Fax: 713-529-0780