# 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 Chapte
440 Louisiana St. Ste 900
Houston, TX 77002

Phone: 713-529-0126 Toll-Free: 800-458-7870 Fax: 713-529-0780