

2018 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?) <input type="checkbox"/> Yes <input type="checkbox"/> No	School name: _____
Insurance: <input type="checkbox"/> Private <input type="checkbox"/> Medicare <input type="checkbox"/> Medicaid	Are you receiving S.S.I. Disability: <input type="checkbox"/> Yes <input type="checkbox"/> 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 <input type="checkbox"/> No <input type="checkbox"/>	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)

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
3701 Kirby Drive, Suite 700
Houston, TX 77098
Phone: 713-529-0126 or 800-458-7870 Fax: 713-529-0780