Physician Verification Form

Dear Physician:

Your patient, identified below, has applied to the Lupus Society of Illinois (LSI) for assistance through the Living With Lupus Program. This program is designed to assist lupus patients who are unable to provide personal care for themselves or who have needs not covered by insurance plans or other sources of assistance. Patients must have a verified diagnosis of lupus, must reside in Illinois, and must demonstrate financial need. The Living With Lupus Program is considered a fund of last resort, and it is limited and temporary in scope.

As the patient's physician, we need verification of diagnosis in order for this patient to be eligible to receive assistance under the Living With Lupus Program. We also would like your recommendation on funding approval. For example, is this patient's lupus severe enough to warrant inability to work, and thus require assistance with medical bills? We ask that you fill out this verification and forward it to the LSI office as soon as possible. Thank you in advance for your assistance.

Patient's Name:_____

Address: _____City: _____ State: _____ Zip: _____

Day Phone: (____)_____ Evening Phone:(____)_____

Patient is requesting financial assistance for:

_____

_____

_____

Verification (This <u>entire section</u> must be completed by the Physician for eligibility)

This certifies that _____ has been diagnosed with ___ Discoid or ____ Systemic Lupus Erythematosus and is currently under my care.

It is my opinion that the patient's medical condition, as it relates to his / her lupus, warrants the above services / items requested because:

_____

_____

_____

Physician's Name (please print): _____Specialty: _____

Office Address: _____ City: _____ State: _____Zip:_____

Office Phone: (_____)_____ FAX: (_____)_____

Physician's Signature: _____ Date: _____

_____

Please Mail or FAX form to:
Lupus Society of Illinois, 411 S. Wells St., Suite 710; Chicago, IL 60607
FAX: 312-255-8020 • 800.2LUPUS2 • www.lupusil.org

About the Lupus Society of Illinois

The Lupus Society of Illinois was formed in April of 1973. Our mission is to improve the diagnosis and treatment of lupus, support individuals and families affected by the disease, increase awareness of lupus among health professionals and the public and find the causes and cure.

Our vision is to be the recognized source on lupus in the state of Illinois, while ensuring that a cure for lupus is found.

Our goal is to defeat lupus and eradicate its unpredictable and devastating effects.

The Living With Lupus Grant Program is made possible through the generosity of our members and donors.

Lupus Society of Illinois

Lupus Society of Illinois
411 S. Wells St., Suite 710
Chicago, IL 60607
800.2Lupus2/800.258.7872
312-542-0002
(fax) 312-255-8020
www.lupusil.org

The Living With Lupus Grant

The Lupus Society of Illinois (LSI) has established the Living With Lupus Grant Program to assist lupus patients in need. Requests considered through this program include lupus-related medical expenses that would help alleviate some of the financial strain those living with lupus face.

The following are examples of appropriate requests:

- Blood work/lab tests
- Hospital bills
- Medical expenses not covered by insurance

Grant Guidelines & Eligibility

- The grant applicant must be a lupus patient or parent/guardian of a lupus patient living in the state of Illinois. Preference will be given to those with a relationship with LSI.
- The LSI will contribute toward payment of valid services or items not covered by other available resources. Grants will not be made in cases where assistance is available from other sources, such as family, social agencies, government programs, etc.
- The applicant must complete the standardized grant application form, verifying financial need and eligibility.
- The applicant must include a paragraph explaining in detail their need for the grant.
- Grants are limited to one request per person during any twelve month period, unless LSI has a qualifying application deficit. In which case applicants can reapply for another annual maximum grant of $400.
- When possible, grants are paid directly to the service provider or vendor— not the applicant.
- Expenses may be reimbursed to the applicant in certain circumstances. A detailed receipt for services is required in all of these situations.
- All individuals receiving the grant will be required to provide LSI a statement detailing how the grant impacted his/her life.
- Applicants will be evaluated by the LSI staff and/or Board of Directors.

Please sign to indicate you have read and understood the grant guidelines and eligibility.

_____

Applicant Signature

GRANT APLICATION

Name: _____ Spouse/Partner Name:_____

Address: _____

City: _____ State: _____ Zip: _____

Day Phone: (____)_____ Email: _____

I am a member of the LSI: _____ I belong to a support group: _____ I participate in the Illinois Lupus Walk: _____

Have you applied for financial help within your county, city and/or State of Illinois? __ YES __ NO

If "NO" Why: _____

Has it been 12 months since you received the Living with Lupus Grant? ___NO __ YES, month & year received: _____

Which most closely represents your need: (Supporting documents must be included in application.)

_____ Blood work/lab tests _____ Hospital bill _____ Medical expenses not covered by insurance _____ Physician/specialist visit

I am requesting financial assistance for: _____

_____

Amount of Assistance Requested: $_____ Date of Request: _____

I certify that all information on this document is true. (please sign) _____

MEDICAL HISTORY

Date of Lupus Diagnosis: _____

Current Treating Physician's Name (to complete page 2):

_____

Date of last visit to Rheumatologist: _____

MEDICAL COVERAGE

Are you covered by a private insurance plan? ___yes___no

If yes, please state plan: _____

Do you receive the following? ___SSDI (RSDI) ___SSI

If yes, please state the amount: $ _____

Are you covered by the following? ___Medicaid___Medicare

INCOME VERIFICATION

Employer / Source of Income: _____

Gross Monthly Income: _____

Partner's Employer: _____

Gross Monthly Income: _____

Other Income: _____ # Dependents: _____

(Please attach copies of your/your partner's most recent pay check / stub)

RESIDENCY

Program applicants must be residents of the state of Illinois. Please verify your residency by attaching a photocopy of either your Driver's License or other verification of residency, such as telephone, gas, or electric bills.

I give my permission for the LSI to contact any entity named herein for verification of these facts. *(Signature Required)*

Signature: _____ Date: _____

Any authorized payment for services / items are made directly to a provider chosen by applicant and approved by the Lupus Society of Illinois. Please state the individual / company who will be providing the services / items.

Name: _____ Phone: _____

Address: _____City: _____ State: _____ Zip: _____

☐ I request the Living with Lupus Grant to reimburse a previously paid medical expense (detailed receipt attached)

Mail form with attachments to: Lupus Society of Illinois, 411 S. Wells St., Suite 710; Chicago, IL 60607

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