LUPUS COLORADO
Help for Today • Hope for Tomorrow

Lupus Colorado
7853 E. Arapahoe Court, Suite 3100
Centennial, Colorado 80112
Phone: 303.597.4050
Fax: 303.597.4054

EMERGENCY ASSISTANCE FUND

The Mission of the Lupus Foundation of Colorado (LFC) is to improve the quality of life for people living with Lupus by advancing community awareness and education, promoting patient and family services, providing advocacy, and by promoting research for the prevention, early diagnosis, effective treatment and discovery of a cure for this debilitating disease.

The LFC Assistance Fund is intended to assist with expenses related to the health, safety and well-being of an individual diagnosed with lupus.

A family member or medical professional may make a request on behalf of a patient who is too ill to do so independently. Our staff members are available to provide assistance with the application process, if desired. When appropriate, LFC will refer the applicant to additional community resources that may be able to help.

ELIGIBILITY QUALIFICATIONS

1. Recipient must be diagnosed with Lupus by an accredited medical professional.
2. Applicant must be able to demonstrate financial hardship and show that his/his budget is not capable of covering the emergency expense.
3. Applicant must be a resident of the state of Colorado.
4. Applicant must not have received assistance from this program in the last 12 months.

REQUIRED DOCUMENTATION

1. **Completed Application** (attached).
2. **Signed doumentation of positive Lupus diagnosis** by accredited medical professional on clinic or hospital letterhead.
3. **Completed Monthly Budget Form** (attached) which details the applicant's average monthly income and expenses.
4. **Copy of the bill for service to be paid or appropriate documentation.**
5. Copy of state-issued **Photo ID.**

APPLICATION PROCEDURE

1. The attached request form must be completed with accompanying documentation as required. **The application must be filled out completely.** We are unable to process incomplete applications.

2. The request for Emergency Assistance funds should be submitted to:

LFC EMERGENCY ASSISTANCE COMMITTEE
Lupus Colorado
7853 E. Arapahoe Court, Suite 3100
Centennial, Colorado 80112
Phone: 303.597.4050
Fax: 303.597.4054
inez@lupuscolorado.org

3. Request will be considered by LFC Emergency Fund Administration Committee. Completed applications are typically processed within 2-3 business days. Applicants will be notified of the Committee's decision by a Lupus Foundation of Colorado staff member.

4. If the request is approved, payment will be made directly to the organization/vendor/creditor for the exact amount.

5. All requests and personal information will be kept confidential by the Lupus Foundation of Colorado.

PAYMENT GUIDELINES

1. Payments for medical services for the patient with lupus will receive first priority.

2. Rent deposits will not be considered for emergency assistance.

3. Car payments/insurance will not be considered for emergency assistance.

4. Payment will only be made to vendors.

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EMERGENCY ASSISTANCE APPLICATION

CONTACT INFORMATION

Name:		Today's Date:	
DOB:		E-mail:	
Address:		Phone:	
City:		State:	ZIP Code:

1. PLEASE STATE YOUR REQUEST FOR ASSISTANCE:

2. PLEASE TELL US WHY THIS EXPENSE SHOULD BE CONSIDERED URGENT OR AN EMERGENCY:

3. PLEASE DESCRIBE FACTORS CONTRIBUTING TO YOUR CURRENT FINANCIAL SITUATION (for example: Are you currently working? Do you have health insurance? Are you waiting for a decision on your disability claim?)

4. WHAT IS THE ESTIMATED COST OF THE PRODUCT/SERVICE/PAYMENT?

5. LIST ALL COMMUNITY ORGANIZATIONS OR RESOURCES YOU HAVE APPROACHED FOR ASSISTANCE WITH THIS EXPENSE:

Name of Organization	Contact Person	Date	Funds Provided or Reason for Denial

6. PLEASE LIST THE AMOUNT YOU CAN PERSONALLY CONTRIBUTE TOWARD THIS EXPENSE:

7. IS THIS AN ONGOING EXPENSE? HOW TO YOU PLAN TO MANAGE THIS EXPENSE IN THE FUTURE?

8. IF YOUR REQUEST IS APPROVED, WE NEED THE FOLLOWING INFORMATION ABOUT THE PAYEE:

Company, Clinic or Individual:		
Contact Person:		
Address:		
City:	State:	ZIP Code:
Phone:	Fax:	E-mail:
Best time to contact?		

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MONTHLY BUDGET WORKSHEET

Please list all monthly household expenses below. If you have additional expenses (such as credit card payments, hospital bill payments, etc.), please itemize and add them in the "other" category.

HOUSING		
Name:	Today's Date:	
Rent/Mortgage:	Heat:	Water:
Phone:	Electric:	Homeowner's Insurance:
Other (please list):		

MEDICAL AND DENTAL EXPENSES	
Insurance Premium:	Copays/Doctor Visits:
Prescription Meds:	Lab Work:
Other Medical Needs (please list):	

TRANSPORTATION	
Car Payment:	Car Insurance:
Fuel & Maintenance:	Public Transportation:
Other (please list):	

PERSONAL EXPENSES	
Food/Groceries:	Clothing:
Personal Care Items:	Other:

HOUSEHOLD INFORMATION How many people reside in your household?	
# of Adults:	# of Children under the age of 18:
Please list the names and ages of dependents:	
1	2
3	4
5	6

TOTAL MONTHLY INCOME $___________________________

Other Household Assistance (please check all that apply):

___Aid to the Needy Disabled (AND)	___Food Stamps	___Old Age Pension (OAP)
___Temporary Aid to Needy Families (TANF)	___Social Security Income	___Social Security Disability Income (SSDI)
___Supplemental Security Income (SSI)	___Woman Infants and Children (WIC)	___Section 8 Housing