PLEASE READ CAREFULLY AND COMPLETELY

Lupus Alliance of Long Island/Queens

Enclosed please find an application form for the LALIQ Quality of Life Grant Program. Please complete the entire form and mail/fax back to us at your earliest convenience. To be eligible for any of our grants ***you must be a current member of the LALIQ before you apply***, (complimentary membership is offered if you cannot afford it, but you still must fill out an application to be a member). You must also be resident of Queens, Nassau or Suffolk Counties and be able to provide evidence of financial need and verification of a diagnosis of lupus. Applications are reviewed by the ***Quality of Life Program*** Coordinator to assess eligibility and determine need.

The Physician Verification Form is to be filled out by the doctor who currently treats you for lupus. ***Income Verification can be shown by a photocopy of a recent pay stub, income tax form, proof of SSI or SSD payment and any verification of alimony or social service assistance. Please note that if you are applying for a minor under 18, income verification of the parent(s) and/or step-parents living with the child must be given. IF THE REQUESTED DOCUMENTATION IS NOT GIVEN, YOUR APPLICATION WILL NOT BE PROCESSED.***

The ***Quality of Life Program*** contributes toward payment of services such as home health care, medical equipment, medication co-pays, wigs, transportation related to medical needs and other products and services that will help alleviate some of the trauma of living with lupus. This program does not pay for recurrent living expenses such as rent, or utility bills or services or items covered by other community resources. **You can apply for this grant one time per year if needed, however being approved in the past does not necessarily mean you will be approved for it again.**

Please disclose all of the information requested. Receiving help from social services or disability **does not** mean you will be denied this grant; however not disclosing pertinent information regarding your income or housing, can be cause to disqualify you for the grant.

Upon receiving the completed paperwork, the committee will review your request and render a decision as quickly as possible. Please do not hesitate to call the LALIQ, if you have any questions about the program or the application process.

Sincerely,

Patricia D`Accolti
Executive Director

3366 Park Avenue, Suite 212 Wantagh N.Y. 11793 (516)-783-3370 Fax (516)-826-2058 info@lupusliqueens.org www.lupusliqueens.org

QUALITY OF LIFE GRANT APPLICATION

A Service of the Lupus Alliance of LI/Q

General Information

Please Print Clearly

Date:_____

Name of Applicant:_____

Spouses Name:_____

***If applying for a minor, please list name of parent(s) including step-parents that live with the minor*:**

_____

Minor`s Date of Birth:_____

Address:_____

Phone:_____**Cell #**_____

E-mail:_____

Number of dependents in family: _____ _____ _____ _____

Self *Spouse* *# of Children and ages* *other*

Grant Information

I am requesting financial assistance for:_____

_____

_____

Have you ever applied for a Quality of Life grant from the Lupus Alliance of LIQ before? _____*Yes* _____*No*

Was it approved? _____*Yes* _____*No.*

If this grant is approved, any authorized payments for services/items are made directly to a service provider chosen by the applicant and approved by the Lupus Alliance of L/Q. Please state the Individual/company who will be providing the service/item. *(For instance a doctor, hospital, pharmacy, medical equipment company etc)*

Name: _____**Phone:**_____

Address:_____

Residency

Are you a resident in the Counties of Queens, Nassau or Suffolk? Yes_____ No_____

(Please attach a photocopy of your Drivers License or other verification of residency such as; Utility bills, lease agreement, State ID, or Mortgage.)

Income Verification

(Please attach whatever proof of income you have, including a photocopy of you/your spouse's most recent pay stub/check, last years income tax return, proof of SSI, or Disability payments, alimony or social services assistance.)

****If you are applying for a minor (under 18), please note we still need to see the income information and verification of the parent(s) including any step-parents living with the minor****

You must give us the income information for <u>every adult</u> in the household. This includes any adult children who may still live with you, and who contribute to the household in any financial way. PLEASE NOTE: receiving social services assistance, unemployment, or even financial help from family, DOES NOT exclude you from receiving or qualifying for this grant. However, if you do not show some kind of income, or how you are able to live, the application will not be considered complete.

Your employers name:_____**Gross monthly income**:_____

Employers address:_____

Spouse's employers name:_____**Gross monthly income**:_____

Spouse`s employers address:_____

Please and enter the amount you receive next to any and all of the following income sources that apply to you.

_____Wages _____Unemployment _____Public Assistance

_____VA Benefits _____Child Support/Alimony _____Food Stamps

_____SSI _____Disability _____Workers Comp

_____Pension _____Other _____SS Retirement

_____ Financial assistance from family or friends _____Temporary Assistance

_____Housing Assistance

Total Monthly Family Income $_____ Total Utility Costs per month (heat, hot water, electric) $ _____

Total Shelter Costs per month $_____

Are you or the child you are applying for covered by a private health insurance plan: Yes____ No____

Are you or the child you are applying for covered by: Medicaid? O yes O no Medicare? O yes O no

If applying for a minor child does child receive SSD or SSI? O yes O no If yes, state amount_____

If applying for a minor child, does said child under a family health plus, or child health plus insurance program? O yes O no

<u>Other circumstances you wish us to consider</u>

_____

_____

_____

_____

MEDICAL RELEASE FORM

I give the Lupus Alliance of Long Island/Queens permission to contact my physician to verify my illness: (***If applying for a minor, parent must sign this consent form***)

Signed _____ Date:_____

Physician Verification Form for Quality of Life Program

Patient Name:_____

Address:_____

Patient is requesting financial assistance for:_____
_____
_____

**********To Be Completed by Physician**********

Dear Doctor,

This form is to verify that the above named party is a patient of yours and has been diagnosed with Discoid and /or Systemic Lupus for the purpose of acquiring a Quality of Life grant through the Lupus Alliance of LI/Q, which helps those with lupus with personal care needs and/or medical bills that they may not be able to pay on their own. Please fill out the form below and ***mail or fax it*** back to the numbers at the bottom of this page as soon as possible. Thank You.

Physician:_____

Speciality:_____

Address:_____

Phone:_____Fax#_____

Patient's Diagnosis:_____

_____

_____

When was the patient diagnosed?_____How long has the patient been under your care?_____

Comments:_____
_____
_____

It is my opinion that the patient's medical condition, as it relates to her/his lupus, warrants the above item and/or service requested.

Physician's signature:_____ Date:_____

Please print your name:_____

Please return to: **Lupus Alliance of Long Island/Queens**
3366 Park Ave, Suite 212
Wantagh, NY 11793

or fax to: 516-826-2058