Help Us Solve
The Cruel Mystery
LUPUS™
FOUNDATION OF AMERICA
PHILADELPHIA TRI-STATE
CHAPTER

101 Greenwood Avenue, Suite 200, Jenkintown, PA 19046
Phone: (215) 517-5070 • Toll-free in PA, NJ & DE @ 866-517-5070 ◆Fax: (215) 517-8483◆
www.lupustristate.org •EMAIL: info@lupustristate.org

HORTENSE GUGGENHEIM GRANT-IN-AID

A Financial Aid Fund called the Hortense Guggenheim Grant-In-Aid has been established to provide limited financial assistance for special or emergency needs for individuals with lupus residing in the Chapter area.

Each request will be limited to a maximum of $200.00 and no more than one grant will be awarded within a 12-month period. There is a three consecutive year limit and a two-year waiting period before an additional grant application will be considered.

Due to the economic downturn and increased requests for assistance, very limited funds are currently available. Applications will be reviewed in the order in which they are received so long as funds are available.

Every request will be carefully evaluated to determine possible resources otherwise available (i.e. personal, family, or community resources, insurance, government benefits, etc). The Lupus Foundation of America, Philadelphia Tri-State Chapter would expect these resources to be utilized before the Foundation will authorize a grant of Guggenheim Funds.

Should requests exceed the available funds, primary consideration will be given to applications from members of our organization. Requests will be accepted only by, or on behalf of, individuals with lupus, or mixed connective tissue disease disorder and any grant authorized, must be related directly, or indirectly, to that individual's condition. Examples of appropriate requests might include rental, purchase or repair of durable medical equipment; co-pays for prescriptions, doctor visits or other short term, non-recurring expenses resulting from a lupus crisis or trauma. **Each need must be verifiable.**

Recurring living expenses such as utilities or rent, etc. are generally considered non-covered items and will not be covered except under extreme circumstances. ◆Please call the Chapter office to discuss your personal situation regarding recurring living expenses before completing this application. Toll-free in PA, NJ & DE: 866-517-5070.

✷**Each application must be accompanied by the individual's health care provider's letter of support which should include the following information:**

- **Applicant name & address**
- **Primary diagnosis and current treatment regimen**
- **Information to support request (e.g. confirmation of diagnosis, medications, a description of the situation and other resources explored.)**
- **Health care provider's signature and date**
- **Health care provider's contact information**

A letter of support from a health care provider (e.g. Physician, Nurse, Social Worker, Physical Therapist) must be submitted on letterhead. A note on a prescription pad, receipt or instruction sheet from DR. /Emergency Room will not be accepted.

All disbursements will be made by check, and generally directed to the service vendor or provider. **Receipts from purchases made must be submitted to the Lupus Foundation of America, Philadelphia Tri-State Chapter within thirty days of receiving check, unless they are provided with your application.**

Please complete the enclosed application to request funds from the Guggenheim Grant-In-Aid fund sponsored by the Lupus Foundation of America, Philadelphia Tri-State Chapter, Inc. Your completed application **must** be accompanied by the required supporting documentation.

Send application and supporting documentation to:
Lupus Foundation of America, Philadelphia Tri State Chapter
101 Greenwood Avenue, Suite 200
Jenkintown, PA 19046

Please call the Chapter office Toll-free in PA, NJ & DE @ 866-517-5070 should you have any questions.

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Applicant's Name _____ DOB: _____

Address _____

City _____ State _____ Zip Code _____

County _____

Telephone (Home) _____ (Cell) _____

Email: _____

Are you a member of the Lupus Foundation of America? ___ Yes ___ No

Person completing this application form _____
Relationship to individual requesting assistance _____

Employment Status: Employed FT ☐ Employed PT ☐ Self-employed ☐
Unemployed - laid off (how long? _____) ☐
Unemployed – homemaker ☐
Unemployed - receiving public assistance ☐
Unemployed – other _____ ☐

Spouse's Name _____ Spouse's Phone Number _____

Spouse's Employment Status: Employed FT ☐ Employed PT ☐ Unemployed ☐

Number of Dependents: _____ Age of Dependents: _____

List current sources of income:

Income source	Amount (monthly)
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

Amount of savings (if applicable): _____

Total Income: _____

List current expenses:

Expense source	Amount (monthly)

Total Expenses: _____

Do you have health insurance? ___ yes ___ no

Does your plan cover prescription medication? ____ yes ____$ co-pay ____ no

Diagnosis: ___ SLE ___ Discoid Lupus ___ Mixed Connective Tissue Disease

___Other (Please List) _____

Amount requested:_____
(Maximum grant is $200)

Please state problem and reason for requesting this grant:

_____

_____

_____

_____

_____

_____

Please attach the following documentation:

_____A letter of support from a current Health Care Provider (e.g. Physician, Nurse, Social Worker, Physical Therapist) ✶Please include all information that is listed at bottom of page 1. **A note on a prescription pad, receipt or instruction sheet from Dr. /Emergency Room will not be accepted.**

_____ And a copy of your most recent pay stub
or
_____ A copy of your Letter of Determination
or
_____ A copy of your SSI/other public assistance statement

By signing this completed application, you state under penalty of perjury that all information is true and accurate to the best of your knowledge. Your signature below grants the Lupus Foundation of America, Philadelphia Tri-State Chapter the authority to confirm the information you have provided in this application, to verify financial information, to contact any/all individuals submitting supporting materials on your behalf, and to contact your physician (s), social worker (s) or applicable government agencies to verify the accuracy of the information provided.
✶**Recipient of this grant agrees to submit receipt/s for purchases made within thirty days of receiving this check. Failure to submit receipts may jeopardize your eligibility to apply for this program in the future.**

Signature _____ Date _____

Checks cannot be made payable to applicant.

If approved, make check payable to: (vendor name):

_____

Send to: Name _____

Address _____

City _____ State _____ Zip_____

Phone _____Fax _____

Please list the account number
associated with this vendor:_____

Documentation of amounts due should be attached. For more information, please contact the Chapter office at 215-517-5070 or Toll-free in PA, DE & NJ: 866-517-5070. E-mail: info@lupustristate.org.

To be completed by Lupus Foundation of America:

Evaluation _____

_____

_____

_____

_____

_____

_____

_____

_____

_____

Amount approved $ _____ Date of Approval _____

Check made payable to _____

Address _____

City _____ State _____ Zip Code _____

Signed _____ Date

_____