Ruby L. Butler Patient Program &
Infinitely You Autoimmune Health and Wellness Program

Many Infinites, Inc. provides patients diagnosed with one or more autoimmune diseases with unique services, directly related to the autoimmune diagnosis. These programs do not provide funding for drug prescriptions. Please complete the application and return to Many Infinities, Inc. to receive help with your autoimmune diagnosis.

Who Should Apply?

Any individual diagnosed with one or more autoimmune diseases, who meets the following criteria, is encouraged to apply for assistance with disease related needs, other than drug prescriptions.

- Applicant must reside in the U.S.
- Applicant must be diagnosed, by a physician, with one or more autoimmune diseases/disorders
- Applicant should be 18 years or older. Applicants under age 18 must be represented by a legal guardian.
- If applying for SNAP Grocery Delivery, applicant must meet all SNAP guideline set forth by the USDA/FNS

How to Apply

When you have determined that you meet the support criteria, follow these steps to complete the application process. All completed applications should be submitted, by mail, to

RLB Patient Program
Many Infinities, Inc.
P.O. Box 1770
Alabaster, Alabama 35007

- Complete the patient information and need form.
- Only your licensed physician should entered on the Medical Records Release Form.
- Provide proof of identity (picture id,)

Other Important Information

- After submitting your completed support application, please allow 7-10 business days for contact regarding your application status.
- Applications may be submitted via postal service or email, to RLB@manyinfinities.org.
- Upon approval of your application, new members will partner with an advocate, who will work to ensure that needs are being met.
- Should you have any questions regarding Many Infinities' programs and services, call us at (205) 258-0222 or email to RLB@manyinfinities.org.

manyinfinities

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Application

Patient Information

Name: _____ Date: _____
Last First MI

Address: _____
Street City State Zip

Phone: (___) ____-_____ Alternate Phone: (___) ____-_____ Email: _____

SSN#: ____-____-_____ ☐ Male ☐ Female Autoimmune Diagnosis: _____

Are you currently receiving medical treatment for your diagnosis? ☐Yes ☐No

Guardian/Representative Information (If applicable)

Name: _____ Relationship to Patient: _____
Last First MI

Address: _____
Street City State Zip

Phone: (___) ____-_____ Email: _____

Financial Information

Total Gross Household Income: $_____ Household Size: _____

I currently receive:

☐ SSI/SSDI ☐SNAP Benefits ☐Other financial support

Number of people contributing to and dependent on household income.

Insurance Information

I have ☐ Medicaid ☐Medicare ☐Private Insurance.

Insurance Co. _____ Phone: _____ Policy #: _____

Group ID: _____ Subscriber's name: _____ Date of Birth: ___/___/_____

Relationship to patient: _____

manyinfinities

Patient's Full Name: _____

Self-Assessment

The following statements are true. Check all that apply.

- ☐ I need assistance securing products and services related to an autoimmune diagnosis.
- ☐ I do not have insurance and would like to learn more about benefits available to me.
- ☐ I have a hard time adhering to my doctor's instructions.
- ☐ I have little to no understanding about my/my loved one's autoimmune diagnosis and how to manage it.
- ☐ I am/my loved one is home bound and requires in-home support.
- ☐ Dealing with an autoimmune diagnosis often become overwhelming and causes feeling of extreme sadness.
- ☐ I would like to learn to understand my body's nutritional needs to manage my autoimmune health.
- ☐ I am/my loved one is not comfortable and rarely understands what is happening during doctor visits.
- ☐ Daily tasks, around my home, around becoming more difficult for me.
- ☐ I am/my loved one is not able to work a full-time job, due to unpredictable autoimmune flare ups.
- ☐ I am/my loved one is a SNAP recipient and physically unable to shop for grocery.
- ☐ My immediate family is affected by my/my loved one's autoimmune diagnosis
- ☐ I am/my family is interested in participating in the Autoimmune Lifestyle Study.

Please note that the details of your assistance are tailored to your circumstances. All details, including the type of assistance you receive will be determined by Many Infinite, Inc.. Upon program acceptance, details will be explained in your program award letter.

Patient Declaration

I _____ declare that

- The information provided in this application is true to the very best of my knowledge. I have neither withheld nor misrepresented any information provided.
- Upon establishing my autoimmune support plan, I will adhere to all program terms set forth by Many Infinities, Inc.
- I understand that Many Infinities, Inc. has the right to discontinue service or deem me ineligible for program services if all program terms are not met.
- Many Infinities, Inc., its representatives, and agents are not liable for any and all claims, injuries, damages, or loses arising out of or resulting from products and services for which I may receive assistance.
- I will notify Many Infinities, Inc. within thirty (30) days of any change in the status of my eligibility (income, household size, diagnosis, etc.) to receive services.
- My application does not guarantee that I receive every service provided by Many Infinities. I further understand that I will be notified of a reapply date and may apply for assistance on or after the designated date.
- Many Infinities, Inc. will assess the information provided and collaborate to establish the best plan of action for my circumstances
- Many Infinities, Inc. will maintain confidentiality and only share the necessary information with program partners, as it directly relates to assisting my needs and services provided, as related to my autoimmune diagnosis.

Patient's Name: _____ Legal Guardian/Rep: _____

Signature: _____ Date: _____

Many Infinities, Inc.

Medical Records Release Form

Patient's Full Name: _____ D.O.B: ____/_____/_____ S.S.N: ____-_____

Physician Consent and Information

I _____ give my consent to my licensed physician/healthcare provider, _____,
(patient's name) (healthcare provider)
to release my private medical information, for purposes related to support for an autoimmune disease or disorder, to Many Infinities, Inc. I understand that Many Infinities, Inc. will only use the provided medical information to proof of an autoimmune diagnosis, to track improvements in my disease management and to determine the best support plan for my wellness. Many Infinities, Inc. will only share this information as it relates to services provided. I further understand that my physician nor any representatives are responsible for harm, damage, or loss occurring as a result of the product or service for which I am requesting assistance.

Patient's name: _____ Legal guardian/Rep: _____

Signature: _____ Date: _____

Check the applicable box.

☐ Please release my full medical record

☐ Please release my medical records for this date range

Start: _____/_____ End: _____/_____
Month Year Month Year

FROM

Physician's Name: _____ Facility Name: _____

Address: _____ Phone: (___) ____-_____ Fax: (___) ____-_____
Street City State Zip

Office Contact Name: _____ Email: _____

TO

Many Infinities, Inc.
Member Records
P.O. Box 1770
Alabaster, Alabama 35007
(205) 258-0222
RLB@manyinfinities.org