Application for

FINANCIAL ASSISTANCE FOR CATARACT SURGERY & PROSTHETIC EYE PROGRAM (LCF VII)

☐ CATARACT SURGERY ☐ PROSTHETIC EYE

DATE

LIONS CLUB INFORMATION

SPONSORING LIONS CLUB

RESPONSIBLE LIONS CONTACT

RECIPIENT'S INFORMATION

NAME	SSN	SEX ☐ FEMALE ☐ MALE	AGE
ADDRESS			
CITY	STATE	ZIP	
HOME PHONE NO. ( )	WORK PHONE NO. ( )	NUMBER OF DEPENDENTS	AGES

WORK INFORMATION

EMPLOYER	OCCUPATION	
ADDRESS		
CITY	STATE	ZIP
PHONE NO. ( )	SALARY / MONTH	HOW LONG HAVE YOU BEEN EMPLOYED?

FINANCIAL INFORMATION

DO YOU RECEIVE ANY OTHER INCOME? *(EXAMPLE: SOCIAL SECURITY, DISABILITY OR AID TO DEPENDENT CHILDREN)* ☐ YES ☐ NO	SOURCE	AMOUNT PER MONTH
DO YOU RECEIVE ANY ASSISTANCE FROM ANY CHARITY? *(EXAMPLE: MONIES, ETC.)* ☐ YES ☐ NO	SOURCE	AMOUNT PER MONTH

MONTHLY EXPENSES

	AMOUNT		AMOUNT
1. RENT OR HOUSE PAYMENT	$	6. INSURANCE	$
2. TRANSPORTATION	$	7. FOOD	$
3. UTILITIES	$	8. MEDICAL	$
4. CABLE	$	9. MISCELLANEOUS	$
5. TELEPHONE	$	**TOTAL MONTHLY EXPENSES**	$0.00

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FINANCIAL INFORMATION CONTINUED

DO YOU HAVE ANY FAMILY WHO WOULD ASSIST WITH THE PAYMENT OF YOUR MEDICAL OR DOCTOR BILLS? ☐ YES ☐ NO	NAME	AMOUNT

INSURANCE INFORMATION

DO YOU HAVE MEDICAL INSURANCE OR ARE YOU COVERED BY MEDICARE, MEDICAID OR OTHER INSURANCE? ☐ YES ☐ NO	PLAN NAME
POLICY / CLAIM / CASE NO.	

GROUP NO.	EFFECTIVE DATE	END DATE

MEDICARE	MEDICAID

ASSISTANCE NEEDED – SELECT ONE

☐ CATARACT SURGERY: ☐ LEFT EYE ☐ RIGHT EYE ☐ BOTH EYES

☐ PROSTHESIS: ☐ LEFT EYE ☐ RIGHT EYE

HAS PATIENT BEEN SEEN BY AN EYECARE SPECIALIST? ☐ YES ☐ NO

IF YES, WHO: _____

IF NOT, WHO RECOMMENDED NEED FOR SURGERY OR PROSTHESIS? _____

ESTIMATED COST $	

CO-PAY

CO-PAY IS $100 (PER EYE PROCEDURE) AND MUST ACCOMPANY APPLICATION. LCF WILL REFUND CO-PAY IF SURGERY IS NOT NECESSARY.	☐ YES ☐ NO

PATIENT'S SIGNATURE _____ DATE _____

LIONS CERTIFICATION

DATE CLUB REPRESENTATIVE VISITED PATIENT _____

I CERTIFY THE PATIENT WAS VISITED BY A CLUB REPRESENTATIVE ON THE DATE SHOWN ABOVE AND THAT ALL INFORMATION PROVIDED BY THE PATIENT HAS BEEN VERIFIED AS ACCURATE.

CLUB SPONSOR SIGNATURE	DATE

INDIGENT CHAIRPERSON SIGNATURE	DATE

LCF ACTION TAKEN

DESCRIPTION OF ACTION TAKEN

DATE	AMOUNT RECOMMENDED $	

Please email application to current foundation secretary and to LCF indigent eyecare chariperson.

See www.lcfsv24i.org for current secretary and indigent eyecare chairperson.