VISIONFIRST - INDIANA LIONS EYE BANK
OCULAR SURGERY ASSISTANCE PROGRAM
4745 HAVEN POINT BLVD • INDIANAPOLIS, IN 46280

Information and Instructions

These instructions have been designed to assist in the completion of the individual Assistance Application. Please read the instructions carefully. If a question does not apply, write in "N/A".

Lion/Lioness Club sponsors should work with the applicant to help complete the information. If the space provided is not adequate, additional pages may be used to answer questions more completely.

OBJECTIVE:

To provide financial assistance to residents of Indiana who need ocular-related surgery and/or treatment but who are unable to fund such services themselves.

OCULAR SURGERY AND TREATMENT:

This program is intended to cover ocular surgery and treatment for persons with failing vision to the point of 20/40 or worse in each eye. It includes, but is not limited to: (1) corneal transplants, (2) cataract surgery, and (3) laser treatment related to diabetic retinopathy.
It is not intended to cover procedures whose purpose is cosmetic or to simply correct vision, (e.g. eye exams, eye glasses, laser procedures when blindness is not eminent).

ASSISTANCE AVAILABLE:

Eligible persons may qualify to receive grants for Ocular Surgery and Treatment. The eligible amount will be determined at the time of the request. The eligible amount will not include amounts covered by Medicare, Medicaid, health insurance nor grants available from other sources.

OTHER CONSIDERATIONS:

The patient may be eligible for aid from other sources such as Helping Hands, Local Governments, Welfare or private foundations. The available assistance should be reviewed and eligible expenses adjusted if appropriate.
Physicians and other medical providers often reduce their fees for those in need of financial assistance. The Eye Bank reserves the right to help assure that the appropriate fees are obtained and reflected when determining Eligible Expenses.

Medicaid has special rules for coverage of Medicaid-eligible persons. Generally Medicaid eligible persons would not receive a grant under this program.

THE GRANT PROCESS:

1 The person needing assistance should contact a local Lions member.

2 If the local Lions Club believes the person may qualify, the application can be down loaded from our website: www.visionfirst.org

3 The Patient and Sponsor Club will complete the application and forward it to an Eye Bank trustee.

4 The Eye Bank in coordination with the local Lions will review the application and contact appropriate persons when a decision has been made.

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Date Received:_____Approved: Y N Date Approved:_____Amount Approved:$_____

Assistance Application

1. Person Requesting Assistance:_____

Address: _____

City/State/Zip: _____

Home phone: _____ Cell phone: _____

Date of Birth:___-___- ____ Age: ____ Social Security #: _____

2. Parent/Guardian (If Child): _____

Address (If Different): _____

City/State/Zip: _____

Home phone: _____ Cell/Work phone: _____

3. Reason(s) for request: (diagnosis and treatment needed)

_____

_____

_____

_____

_____

4. Sponsoring Lions Club: _____

a. Has the club investigated the need for assistance?_____

b. What is the total of the funds requested from the VF-ILEB? _____

c. Did the club negotiate fees with the service provider(s) or supplier(s)? Did the service provider or supplier agree to accept a reduced fee for this applicant? Explain:

_____

_____

d. How will the Local Lions Club assist the applicant (special events, amount to be contributed, etc.)?

_____

_____

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5. Please explain any current financial/health conditions that contribute to your need for assistance:

_____

_____

_____

_____

6. Is the applicant covered by health insurance, Medicaid or Medicare? _____

Company/HMO: _____

List Coverage Limitations: _____

7. Optometrist/Ophthalmologist: _____ Date Last Seen

Address: _____ ____-___-_____

City/State/Zip: _____

Telephone Number: _____ Fax Number _____

Other Doctor(s) involved and Phone Number(s):_____

_____

_____

_____

8. List members in household excluding applicant:

Name	Relationship	Age

_____

_____

_____

_____

_____

_____

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FINANCIAL INFORMATION

9. ANNUAL HOUSEHOLD INCOME: **(Attach most recent Tax Return)**

Wages, Salary, and Tips	$ _____
Unemployment Compensation	$ _____
Social Security Benefits	$ _____
Welfare Benefits	$ _____
Veterans Benefits	$ _____
Alimony and Child Support Received	$ _____
Interest and Dividend Income	$ _____
Business Income (or Loss)	$ _____
Capital Gain (or Loss)	$ _____
IRA	$ _____
Pensions and Annuities	$ _____
Rental Income	$ _____
Farm Income (or Loss)	$ _____
Other Income	$ _____
Total Income	$ _____

10. ESTIMATED ANNUAL HOUSEHOLD EXPENSES:

Rent (House, Apartment, etc)	$ _____
House Payment	$ _____
Home Owners Insurance	$ _____
Renter Insurance	$ _____
Monthly Electric Bill	$ _____
Gas (Natural or LP) Bill	$ _____
Telephone (Land Line & Cell)	$ _____
Automobile Payment(s)	$ _____

Health and Life Insurance	$ _____
Medical and Dental Expenses	$ _____
Food & Consumable Items	$ _____
Clothing	$ _____
Child Care	$ _____
Education	$ _____
Child Support	$ _____
Other Expenses	$ _____
Total Annual Household Expenses	$ _____

11. OUTSTANDING LOANS:

Institution	Purpose	Monthly Pmt

12. SAVINGS AND INVESTMENTS:

Institution	Source	Amount

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VisionFirst - Indiana Lions Eye Bank may see further medical, financial or other information as required, and it is understood by all parties that all approved funds shall be used for the intent and purpose stated in this application. Any and all unexpected funds shall be returned to VisionFirst - Indiana Lions Eye Bank in a timely manner.

_____ _____
Applicant, Parent, or Guardian (Signature) Date

_____ _____ _____
Lions Club Representative (Printed) Date Phone #

_____ _____ _____
VF-ILEB Trustee (Printed) Date Phone #

VF-ILEB TRUSTEE RECOMMEDATION/INFORMATION:

_____

_____

_____

_____

_____

_____

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MEDICAL INFORMATION RELEASE/AUTHORIZATION

I, _____

Hereby authorize Dr.(s)_____

_____

To release and/or discuss my medical information with VisionFirst - Indiana Lions Eye Bank to determine the need for assistance through the Ocular Surgery & Treatment Program.

This authorization shall be in effect until_____at which time this authorization to use or disclose this protected information expires.

I understand I have the right to revoke this authorization, in writing and at any time by sending such written notification to VisionFirst - Indiana Lions Eye Bank.

I understand the revocation is not affected to the extent that VisionFirst - Indiana Lions Eye Bank has relied upon it and has used the authorization to conduct a review of my application.

The health provider and their staff, officers, and review committee are hereby released from all legal liabilities for the release of the above requested information to the extent authorized herein.

I understand my right to refuse to sign this authorization.

DATE:_____ _____

Signature of Applicant/
Personal Representative or Guardian
Authorized to Release Information