**ROCKY MOUNTAIN LIONS EYE BANK**
**EYE SURGERY FUND APPLICATION**
**COVER SHEET**
**To be completed by sponsoring Lions Club**
**(See separate attachment for Application Qualifications and Procedures)**

(This form must be used for all applications on or after 7/09/16)

Applicant's Name_____ Age_____

Sponsoring Lions Club_____

Responsible Lion: Name_____
Street Address_____
_____
City, State, Zip Code_____
Phone (_____) _____-_____
Best time to contact_____
Email_____

Required Surgery_____
Left eye (OS)_____ Right eye (OD)_____ Both eyes (OU)_____
Other_____

Total Cost of Surgery (reduced amount) _____
(Maximum ESF grant amount is 80% of Medicare rates)
Requested Amount from the Eye Surgery Fund_____
Amount from the sponsoring Lions Club_____
Amount from other source or patient_____

TO BE COMPLETED BY THE DISTRICT EYE BANK DIRECTOR
Application reviewed and presented by District Eye Bank Director_____

Payment for surgery should be sent to:

Director_____ Sponsoring Lions Club_____

Date Submitted: _____ Date Approved: _____

Motion: _____ Second: _____

## Rocky Mountain Lions Eye Bank (RMLEB) Eye Surgery Fund Application
## APPLICANT PORTION
### Lions Club Interview with Applicant to Determine Financial Need

1. Applicant Name _____
   First Last
2. Address _____
   Street Unit #
   _____
   City State Zip Code
3. Phone _____
   Home Work
4. Date of Birth _____ 5. Gender _____
6. Marital Status _____ 7. Length of residency in state _____
8. Below please list family members dependent on household income.

| Name | Age | Relationship |
|---|---|---|
| | | |
| | | |
| | | |

9. Name of Parent or guardian, if applicable_____
10. Has prior application been made for assistance to RMLEB Eye Surgery Fund? _____
    If yes, describe circumstances _____
11. Is applicant a U.S. citizen? _____
12. Employer _____
13. Employer's Address _____
    _____
14. Dates of Employment _____
15. If not employed, please explain applicant's means of support. _____
    _____
16. Can any member of applicant's family contribute toward surgery costs? _____
    If yes, to what extent? _____
17. Has applicant applied for assistance for eye surgery and/or hospitalization from Medicare/Medicaid, Welfare, Aid to the Blind, Medical Aid for the Aged, Veterans Affairs, etc.? _____
    If yes, provide agency name and decision _____
18. Does applicant have insurance? _____ (Medicare/Medicaid are government insurance)
    If no, please explain _____
    If yes, provide company name and policy number. _____
    Decision of insurance company to cover eye surgery costs _____
19. Total monthly household income (wages, retirement, food stamps, WIC, other subsidies)
    Sources of income: _____ $_____
20. Total monthly household expenses (housing, food, transportation, utilities, insurance, etc.)
    $_____
21. Value of Assets:
    Real Estate $_____
    Checking, savings accounts $_____
    Life insurance cash value $_____
    Stocks, bonds, other assets $_____
    Personal property (vehicles, etc.) $_____
22. Total Net Assets $_____
23. Please list liabilities and debts with amounts (continue on back of this sheet if necessary):
    _____ $_____
    _____ $_____
    _____ $_____
24. Total Liabilities and Debts $_____
25. Please describe any unusual or extenuating circumstances concerning the nature of income or debt.
    _____
    _____
26. If financial situation improves, would applicant be willing to repay grant? _____

**Expenses:**

| | |
|---|---|
| **Rent/Mortgage** | **$ _____** |
| **Utilities** | **$ _____** |
| **Cell Phone** | **$ _____** |
| **Food** | **$ _____** |
| **Insurance _____** | **$ _____** |
| **Other** | |
| **_____** | **$ _____** |
| **_____** | **$ _____** |
| **_____** | **$ _____** |
| **_____** | **$ _____** |
| **_____** | **$ _____** |
| **_____** | **$ _____** |
| **Total** | **$ _____** |

Patient name: _____ Date of Birth_____

# Rocky Mountain Lions Eye Bank (RMLEB) Eye Surgery Fund Application

## APPLICANT PORTION (CONT.)

### Indemnification and Consent for Use and Disclosure of Personal and Health Information

I attest that, to the best of my knowledge, the above information is correct.
I understand any misrepresentation or falsehood of the above application will result in immediate and permanent disqualification from consideration.

I hereby release RMLEB and its agents of any responsibility for injury or mistreatment in connection with any procedure or surgery funded by RMLEB.

I further absolve RMLEB from any liability resulting from any unsuccessful procedure or from future reoccurrence of my (or applicant's) disorder or disease.

I consent to any photographic or video graphic image taken in connection with the treatment of myself (or applicant) and authorize use of same images by RMLEB now and in perpetuity for public and medical education.

I authorize the use and disclosure by RMLEB of personal and health information of or about me (or applicant) as described in this form, including medical, dental, and pharmacological information.

I understand such information may have been provided by other persons or entities, including physicians and health care providers.

*Any and all personal and health information about me may be obtained and/or maintained by members of _____Lions Club, RMLEB Board of Directors, RMLEB Executive Director. This includes (1) mental health (2) HIV/AIDS, and (3) substance abuse information. (Note to applicant: Cross out the description of any type of information you do not authorize to be released.)

* Personal and health information regarding treatment rendered.
*Other _____

This information may be disclosed to, and used by the following individuals or organizations:

* RMLEB Board of Directors
* Members of _____Lions Club
* Employees of the Rocky Mountain Lions Eye Bank
* Health care providers
* Other _____

This information is being disclosed for the purpose of determining whether, and to what extent, RMLEB and the RMLEB Board of Directors may be able and willing to provide financial assistance to the applicant for treatment and care.
I understand that I do not have to sign this authorization and may revoke it at any time, and that in order to do so, I must do so in writing, delivered to RMLEB's office at the Rocky Mountain Lions Eye Institute Building at 1675 Aurora Ct, F751, Suite #EI-2049, Aurora CO 80045-0358.

I understand that the revocation will not apply to information that has already been released pursuant to this authorization.

I understand that once the information is disclosed pursuant to this authorization it may be further disclosed by the recipient, and it may not be protected by federal privacy regulations. Unless otherwise revoked or extended, this authorization will expire in 365 days.

Signed _____ Date _____
Applicant or Applicant's Legal Representative

If signed by Legal Representative, capacity or relationship to Applicant (i.e. Parent of minor applicant, agent under power of attorney) _____ Date_____

Witnessed by interviewing Lion_____ Date_____

## Rocky Mountain Lions Eye Bank (RMLEB) Eye Surgery Fund Application
## MEDICAL PORTION
## Certification of Medical Need and Fees by Ophthalmologist

Please Note: RMLEB will not assume any financial responsibility prior to issuance of an authorization on RMLEB letterhead with the signature of the Chair of the ESF Committee. Eye Surgery Funds are not available to supplement Medicare/Medicaid or insurance coverage. Working together with the surgeon, the Responsible Lion requests that **fees be waived or discounted as much as possible**. RMLEB-ESF requires funding from other sources to be provided and shown on the Sponsoring Lions Club portion of this application.

1. Patient Name _____
2. Parent or Guardian, if applicable _____
3. General health of patient _____
4. Diseases affecting the eye(s) _____
5. Type of Surgery needed _____

   Right eye_____Left eye_____ Both eyes_____

   Is a cornea needed? _____ Is this a second opinion? _____

6. Please attach copy of exam findings or provide information below.

| | OD | OS |
|---|---|---|
| Vision (corrected) | | |
| Cornea | | |
| Lens | | |
| Tension | | |
| Fundus | | |
| Field | | |
| Additional | | |

Previous treatment(s) for this condition _____

7. Recommended time frame for each surgery _____
   Anticipated number of surgical facility admissions needed _____
   Facility: Name _____
   Address _____ Phone # _____
   Anesthesiologist: Name _____
   Address _____ Phone # _____

8. Our mutual cooperation is dependent on waiver/reduction of fees to the lowest possible level (at or below Medicare rates). Please list usual fees and discounted fees that will be accepted for this case.

| | Medicare Code # | Medicare Allowed | Usual Fee | Discounted Fee |
|---|---|---|---|---|
| Physician Fees (including exam, surgery, post-op care, refraction) | | | | |
| Facility Fees | | | | |
| Anesthesia | | | | |
| Materials (please list) | | | | |

9. Total Fees $_____

Signed _____ Date _____
Ophthalmologist

Print Name _____Practice Name_____

Contact Person_____ Mailing Address_____
Street

_____ _____
Phone Fax City State Zip Code

## Rocky Mountain Lions Eye Bank (RMLEB) Eye Surgery Fund Application
### Lions Club Sponsorship of Applicant

1. How long have you known the applicant? __ _____

   Under what circumstances____ _____

2. Remarks and recommendation concerning this application ____

_____

3. Describe steps taken to obtain reduced/waived physician and facility fees __

_____

4. List funding available from other agencies (insurance, government, public, private) __

.

5. Total cost of surgery (Medical Portion #9 – Total Fees) $____

   a. Financial assistance from the RMLEB Eye Surgery Fund $___

   b. Financial assistance from sponsoring Lions Club $___

   c. Financial assistance from other sources $_____
      Applicant _____
      Family _____
      Other __

6. Total of items a + b + c $_

7. Sponsoring Lions Club _____
   Please Print

Signed _____ Date _____
Responsible Lion of Sponsoring Lions Club

Print name _____

# Rocky Mountain Lions Eye Bank

## Eye Surgery Fund Verification of Surgical Treatment

## For Reimbursement of Services

The Rocky Mountain Lions Eye Bank Eye Surgery Fund Committee requires verification of surgical treatment before Eye Surgery Fund grants can be paid.

**Once surgery has occurred, please mail or fax completed form to the Rocky Mountain Lions Eye Bank, 1675 Aurora Court, MSC F751, Aurora, CO., 80045, (fax) 720-848-3938. If you have any questions, please contact Lion Carole Kitchell, 970-484-9012 or email at c.t.kitchell@usa.net**

Patient Name: _____

Surgeon Name: _____

Address: _____

_____

Contact Person Name and phone: _____

Date of Surgery: _____

Cost of Treatment: _____
(Total expenses including surgeon, surgery center and anesthesiologist.)

Surgeon's Signature: _____

Date Sent: _____

**CLUB CERTIFICATION**

**OUR LION/LIONESS CLUB HAS DETERMINED THE FOLLOWING:**

____ The patient/guardian/parent does not have sufficient financial resources
___ The patient/guardian/parent is not on public assistance.
____ The patient/guardian/parent does not have adequate insurance to provide the treatment nor is he/she covered by Medicare or Medicaid.
____ Our Board of Directors has reviewed the Policies and Guidelines and agrees to abide by them.

# PAYMENT OPTION REQUESTED:

__ __ **OPTION A:** A joint venture with the Lions of Wyoming Foundation and our Lion/Lioness Club each paying 50%. The Foundation will make their half of the payment directly to the vendors upon receipt of copies of the bills.

_____ **OPTION B:** The costs will be paid by the Lions of Wyoming Foundation, upon receipt of the bills from the providers. Fifty percent will be considered a matching grant and the remaining 50% will be considered an interest free loan that will be paid back to the Foundation in the following manner:

_____
_____
_____
_____
_____

**SIGNED:** _____
President of Sponsoring Lion/Lioness ClubDate

**SIGNED:** _____
Secretary of Sponsoring Lion/Lioness ClubDate

**ADDITIONAL INFORMATION OR COMMENTS:**

Please mail all forms/information to:

**Executive Director**
**Lions of Wyoming Foundation**
**224 Talon Court**
**Cheyenne, WY 82009**
If you have any questions, please call: 307-631-5423
email: dorr7111@gmail.com