



LIONS VISION & HEARING FOUNDATION
3124 E. Roosevelt St. Bldg. D #1
Phoenix, AZ 85008
602-267-7573

INSTRUCTIONS FOR OPHTHALMOLOGY ASSISTANCE

Enclosed you will find the application for the request of Ophthalmology assistance. Please complete all of the forms and return it to us plus all other information that is requested on the application.

- A letter from your physician if you have diabetes that states you have medical clearance for surgery.
- A letter from the surgeon stating the type of surgery needed.
- You must include Proof of Income (SSI, SS, Food Stamps, ADC, Interest, Dividends, Royalties, 401K, retirement funds, etc.) If you are required to file income taxes, please submit a copy of last year's tax forms.
- You must also provide Proof of legal residence such as a clear copy of your AZ driver's license or AZ identification card.
- You must provide proof of any health insurance you may have.

*****Please make copies of everything for your records. You may drop this information off in person to our office or mail at the address above.

Once we receive all the information requested, your application will be reviewed by our Sight Committee in the order it is received. The obvious lifestyle of the applicant is taken into consideration and may include an interview with our Office Staff, Administrator, or Lions Club member.

A co-pay of \$150 for Cataract Surgery or a co-pay of \$250 for Retinal Surgery, maximum copay up to \$450 will be required for all ophthalmology surgeries, this co-pay is for surgery for one eye only per year.

Thank you,

AZ Lions Vision & Hearing Foundation



Lions Vision & Hearing Foundation



3124 E. Roosevelt St. Bldg. D #1

Phoenix, AZ 85008

Phone: 602-267-7573

Fax: 602-267-7595

Ophthalmology Request for assistance

MUST BE ARIZONA RESIDENT FOR 6 MONTHS OR LONGER TO QUALIFY

Office use only: Date received _____

Case number _____

Applicant: _____ Sex; Male / Female
(Name; please print clearly)

Address; _____ Email Address: _____

City; _____ Zip code; _____ Phone; (____) _____

Date of Birth; _____ Age; _____.

Contact Person; _____ Phone; (____) _____.

Address; _____

City; _____ Zipcode; _____ Cell Phone; (____) _____

Number of persons in Household; Adults _____ Children _____ How did you hear about us? _____

What is your Ethnicity? White/Caucasian _____ Hispanic _____ African American/Black _____
 Native American _____ Pacific Islander _____ Other _____

Disclaimer: No person shall be discriminated against because of race, religion, gender, sexual orientation, creed, age, color, marital status, physical handicap or disability, national origin, or veteran status.

Number of persons in Household: Adults ____ Children ____ How did you hear about us?

Copay: 10% of Surgery charges, maximum copay up to \$450.00

Monthly Budget (the monthly expenses of your household)

Income: Husband \$ _____ Wife \$ _____ Other \$ _____

****Please list ALL other income to include everyone in the household**

Example - SSI, SS, Food stamps, ADC, Interest, Dividends, retirement Funds, child support, etc.

TOTAL MONTHLY INCOME (please total all of the above) \$ _____

Please List ALL monthly expenses;

Rent / Mortgage Payment	\$ _____
Utilities (phone, gas, water, electric)	\$ _____
Food	\$ _____
Insurance (Auto, Health Life etc)	\$ _____
Installments Payments	
Auto (include final date)	\$ _____
Loans / credit cards	\$ _____

TOTAL MONTHLY EXPENSES \$ _____

If you have NO income, please attach a separate sheet explaining your living arrangements.
See over – Please answer all questions and SIGN the application.

Insurance; AHCCCS, Medicare _____

Do you have Diabetes? _____ You must have a letter from your physician regarding the status of your diabetes before any surgical procedure is approved.

Have you visited a doctor concerning your eyes? YES ____ NO ____

If 'yes', Name of Doctor: _____ Phone: _____
Diagnosis; _____

(Include copies of any information you have concerning your condition)

Important: You must enclose the first two (2) pages of Last Year's Federal Income Tax return if you filed. If you did not file, attach copies of proof of income (W2, check pay stubs etc).

The Lions Vision & Hearing Foundation has not granted any authority, express or implied, to any person, organization, or government agency, including, but not limited to, any person, referral organization, Lions Club or Physician from whom you may have obtained this request for assistance, to act on behalf of, to act on behalf of or to otherwise bind the Lions Vision & Hearing Foundation in any manner whatsoever. Neither this application form, nor your receipt of this application from any such source is a representation from the Lions Vision & Hearing Foundation of any authority, actual or apparent, in such source all such expressions authority are hereby disclaimed. You should direct any questions regarding the services available through the Lions Vision & Hearing Foundation, eligibility for such services, the cost of such services and this *request for assistance* directly to the Lions Vision & Hearing Foundation at the address and/or phone number set forth on this form. There is no application fee associated with the Lions Vision and Hearing Foundation.

Release;

I for myself, my heirs, personal representatives, executors, administrators, and assigns, and on behalf of the patient if the patient is other than myself and I am the responsible party for the patient, waive, release and forever discharge the Lions Vision & Hearing Foundation and the Lions Clubs of Arizona, their officers, directors, agents, representatives, successors and all co-operating entities and individuals from all claims, losses, damages which now exist or may hereafter arise in connection with my and/or the patients participation with any services rendered through Lions Vision & Hearing Foundation.

To the best of my knowledge, I represent the information on this form to be correct. I acknowledge and understand this release thoroughly and authorize any service provider contracted by the Lions Vision & Hearing Foundation to release to the Lions Vision & Hearing Foundation any information required.

I do hereby give the LIONS VISION & HEARING FOUNDATION permission to use my picture in any publicity brochure that is deemed appropriate by the Foundation.

Signature _____ Date; _____

For patients / applicants under 18 years of age;

Any patient under 18 years old **MUST** have an authorization before being accepted. Responsible person has read and understands *request for assistance*. I am willing to accept the services provided by the Lions Vision & Hearing Foundation for this minor child.

I do hereby give the LIONS VISION & HEARING FOUNDATION permission to use my daughter/son picture in any publicity brochure that is deemed appropriate by the Foundation.

After you have read all of this form please sign and date below:

Signature; _____ Date; _____

Relationship to applicant; _____

FALSE STATEMENTS ARE GROUNDS FOR REFUSAL OF BENEFITS

(Office use only);

If referred by a Lions Club _____ Date _____

(Name of club)

Recommended by _____ Phone _____

(Name of referring Lion)

Address _____ City _____ Zip _____

Poverty Income Guidelines

# IN HOUSEHOLD	ANNUAL INCOME	MONTHLY INCOME
1	18,210	1,518
2	24,690	2,058
3	31,170	2,598
4	37,650	3,138
5	44,130	3,678
6	50,610	4,218
7	57,090	4,758
8	63,570	5,298