Lions Eye Foundation of California-Nevada, Inc.
P.O. Box 7999
San Francisco, CA 94120

PRESERVING & RESTORING THE GIFT OF SIGHT

GUIDELINES FOR REFERRING PATIENTS

1. Patient Eligibility

- One year of continuous residency in communities served by the Foundation
- Adjusted Gross Income (AGI[1]) verified within guidelines established May 1, 2014 as follows:

Family Size	1	$ 29,175
Two Income Family	2	$ 39,325
Family Size	3	$ 43,385
Family Size	4	$ 47,445
Family Size	5	$ 51,505
Family Size	6	$ 55,565
Family Size	7	$ 59,625
Family Size	8	$ 63,685
For each additional dependent add $ 4,060		

[1]from line 37 on Form 1040, or line 4 on Form 1040EZ, or line 21 on Form 1040A

- No Health Insurance. Patient must be without coverage (no county, government, or private coverage; no partial coverage, share-of-cost, or deductibles)
- If Assets are greater than $75,000 services may be denied

2. Doctor Referral

- It must first be determined that the patient does indeed have an eye problem requiring treatment and care (excluding eye glasses and contact lenses). A referral from a doctor stating the patient's diagnosis is required.
- Lions Eye Foundation does not provide financial aid for eye glasses nor contacts.

3. Club's Responsibility

- Completion of Physician Referral form, Patient Financial Statement and Patient Release (must be signed by doctor, patient and club representative accordingly). Chart Notes may be used in lieu of doctor signature.
- If possible, provide assistance for transportation to and from appointments in San Francisco (BART, train, bus, money for gas, etc.) as needed. LEF will reimburse clubs a portion of the mileage cost (one-way only) *after* the appointment has occurred. The Transportation Reimbursement Request form and instructions are available on our website.
- If needed, provide glasses after patient has completed treatment/surgery.

4. Questions / Emergencies (retinal detachment, foreign object in eye, etc.) / Forms

- Contact Lions Eye Foundation, Mark Paskvan, Program Coordinator
- TEL: (415) 600-3950 FAX: (415) 600-3949
- Email: PaskvaM@sutterhealth.org
- Web: www.lionseyefoundation.com

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REQUIREMENTS WHEN APPLYING

1. Verification of Income

- Verification of income must be submitted along with your application. Verification of income can be any one (1) of the following four (4) items:

    1. First two pages of your most recently filed federal tax return. This is best.
    2. Copies of your two most recent pay-stubs or unemployment checks.
    3. Copy of your government award letter.
    4. Signed personal letter stating you have no income; and if applicable, stating you are living with/ supported by family

- When submitting your application be certain you include one of the above items.

2. Social Security Number (SSN)

- You must also include your social security number. Write it on the Patient Financial Statement. That is page 2 of 3 of the application.

- If you don't have a Social Security Number please write "no SSN at this time" on Patient Financial Statement. Even without a SSN you are still eligible to receive consideration for Lions Eye Foundation services.

3. Health Insurance Information

- Provide your health insurance information on the Patient Financial Statement. Indicate if you have insurance by checking yes or no to each type of coverage listed in item C. 6. "Do you have"

- Also, state if you have recently applied for any other type of health insurance. Include the name of the insurance program you applied for. If you pay cash for medical services state you are self-pay.

4. Local Lions Club Sponsorship

- Fax or mail your completed application along with verification of income to your local Lions Club. The Local Lions club will review your application to ensure it is complete and ready for submission to the Lions Eye Foundation.

- If you are without contact information for your local Lions Club, please phone the Lions Eye Foundation for assistance. Our telephone number is: 415.600.3950

PHYSICIAN REFERRAL FORM
Lions Eye Foundation of California-Nevada, Inc.
PO Box 7999, San Francisco, CA 94120
Phone (415) 600-3950 Fax (415) 600-3949

TO SUBMIT APPLICATION:

Please include the following:

____Completed Physician Referral Form
____Completed Patient Financial Statement
____Signed Patient Release of Information Form
____Proof of Income
____Medical exam notes and any tests related to eye condition

Mail: Lions Eye Foundation
PO Box 7999
San Francisco, CA 94120

or Fax: (415) 600-3949
Attn: Mark or Monica

Note: Incomplete applications will delay the referral process

Date received:__________Authorized by Screening Committee? D Yes D No Initial: ______

Questions? Please call (415) 600-3950

Date: ______________

Referring Physician: ______________________________ Phone: ______________________

Address: ______________________________ Fax: ______________________
Street

____
City State Zip

Patient:______________________________ Birth date:______________ D M D F
Last First

Address:______________________________ Phone: ______________________
Street

______________________________ Cell: ______________________
City State Zip

Language: ______________________

The patient is being referred for the following reason: D No Insurance D Limited Income

Diagnosis: (Please include complete eye exam, including visual acuity, external, slit lamps, muscles and fundus exams):

____

______________________________ Signed: ______________________________ MD / DO

Sponsoring Lions Club: ______________________________ District: __________

I verify that I have screened this patient with regard to the financial need and have found the patient is eligible for Foundation assistance:

Authorized by: ______________________________ Title: ______________________
Print Name

Address:______________________________ Phone: ______________________
Street

____
City State Zip

Signature:______________________________ Date: ______________________

Note: All correspondence from Lions Eye Foundation will be sent to the address provided

PATIENT FINANCIAL STATEMENT

Lions Eye Foundation of California-Nevada, Inc.
PO Box 7999, San Francisco, CA 94120
Phone (415) 600-3950 Fax (415) 600-3949

PT's Soc Sec #: ______________________

Required entry; if no SSN write n/a

A. Patient's Name: ______________________ Birth date: ______________ D M / D F
Last First

Address: ______________________ Phone: ______________
Street

______________________ Alt Phone: ______________
City State, Zip

Primary Language: ______________ If other than English, whom may we contact? ______________
Name Phone

How long has the patient lived at this address? ________ D Rent D Own

If less than one year, provide previous address and length of stay: ______________________

B. Dependents (if patient is a minor, the following information refers to parent or guardian):

Name	Age	Relationship	Name	Age	Relationship

C. 1. Patient's Current Employment: D Full time D Part Time D Unemployed D Retired

If employed, name of Employer: ______________________

2. Spouse/Partner Employment: D Full time D Part Time D Unemployed D Retired

If employed, name of Employer: ______________________

3. If unemployed, how long since you have worked? ______________

4. Monthly Income **(proof of income required-include copy of last two pay stubs or previous year's tax return)**:

Adjusted Gross Income (AGI): $ __________

If self employed, Gross income: $ __________ OR After tax net income: $ __________

5. List of Assets:

a. Market Value of Home less Amount of Mortgage owed: $ __________

b. Market Value of Other Real Estate less Amount of Mortgage owed: $ __________

*Applicant may be disqualified if the overall net value is more than $ 75,000

6. Do you have:

a. Medi-Cal or Medicaid? D No D Yes, card number: ______________

b. Medicare? D No D Yes

c. Other insurance? D No D Yes, name of plan: ______________

d. Have you ever applied for Medi-Cal or Medicaid? D No D Yes

If yes, describe: ______________________

D. I attest that all statements contained in this application and any accompanying documents are true and correct, with full knowledge that all statements made in this application are subject to investigation and that any false or dishonest answer to any question may be grounds for denial.

______________________ ______________
Signature of Patient or Parent/Guardian Date

______________________ ______________________ ______________
Signature of Authorized Club Representative Club Date

PATIENT RELEASE OF INFORMATION

Lions Eye Foundation of California-Nevada, Inc.
PO Box 7999, San Francisco, CA 94120
Phone (415) 600-3950 Fax (415) 600-3949

I. Explanation: Authorization for use or disclosure of my health information is required by state and federal law.

II. Authorization: This authorization applies to the health information for:

Patient:___________________________________Date of birth: ________________

I, (patient or legal representative) ____

Authorize: ____
(Name and address of entity releasing records)

to release my complete eye exam, including visual acuity, external, slit lamps, muscles and fundus exams to Lions Eye Foundation and affiliate Lions Club.

I hereby authorize the Lions Eye Foundation of California-Nevada, Inc. to make any investigation concerning me and my dependents which is necessary to establish eligibility for assistance.

III. Expiration: The authorization shall become effectively immediately and shall remain in effect until (enter specific date of event):____________________________.

IV. Restrictions: California law prohibits the recipient from making further disclosure of your health information unless the recipient obtains another authorization from you, or unless the disclosure is permitted by law. This protection does not extend to recipients outside the state of California.

V. Your Rights:

- I understand that authorizing the release of this health information is voluntary. I may refuse to sign this authorization.
- I may revoke this authorization at any time. My revocation must be in writing, signed by me or on my behalf, and delivered to this address: Lions Eye Foundation, PO Box 7999, San Francisco, CA 94120. My revocation will be effective upon receipt, but will have no impact on uses or disclosures made while my authorization was valid.
- I have a right to receive a copy of this authorization; the original of this document will be kept on file with Lions Eye Foundation. I may inspect and obtain a copy of the health information that I am authorizing for use or disclosure.

VI. Signature

Signature:____Date: _________________

Print Name: ____

Relationship to patient (if signed by someone other than patient): ________________

Witness (required if signed by someone other than patient): _____________________