Georgia Lions Lighthouse Foundation

Better vision. Better hearing. ***Better Georgia.***

Please complete the eye surgery application and the enclosed questionnaire. Include documentation verifying income for all members of the household.

- Current statements of Supplemental Security Income, Social Security Disability, and Social Security Income, **dated within the last 30 days**
- AFDC, Food Stamps, and Child Support, **dated within the last 6 months**
- Veteran's Benefits, Pensions, Retirement Benefits, **dated within the last 30 days**
- Last four paycheck stubs and last year's income taxes
- Copies of current bill for rent, telephone, and utilities **dated within the last 30 days**
- Unemployment claim, if unemployed submit a wage inquiry statement from the GA Department of Labor, **dated within the last 30 days**
- A **legible** and **enlarged** copy of a valid Georgia Driver's License/ Georgia ID
- Proof of legal U.S. residency (copy of birth certificate, voter's registration card or permanent resident alien card.)
- Copy of current letter from Doctor indicating the need for eye surgery
- Documentation verifying current Medicaid/Medicare denial is required for surgery applications, **dated within the last 6 months**

ANY APPLICATION RECEIVED WITHOUT PROPER DOCUMENTATION WILL BE RETURNED TO YOU. **Your cooperation in this matter will enable us to process your application more efficiently. Thank you.**

Your private Health Information will be protected in accordance with applicable laws.
Revised August 2014
Lions Help Restore Hope

5582 Peachtree Rd Chamblee, Georgia 30341 (404) 325-3630
(800) 718-SITE (7483) Fax (404) 636-5549 www.lionslighthouse.org
A 501c(3) nonprofit organization (gifts are tax deductible).

SIGHT SURGERY APPLICATION
Georgia Lions Lighthouse Foundation, Inc.
5582 Peachtree Rd., Chamblee, GA 30341 Phone: (404) 325-3630
Toll Free: (800) 718-7483 Fax: (404) 636-5549 www.lionslighthouse.org

Guidelines/Directions

1. **Services are provided for legal Georgia residents experiencing extreme financial hardship who are unable to receive assistance from other sources.**
2. **The Lighthouse will not pay for expenses incurred prior to the APPROVAL of an application by the Lighthouse office.**
3. **If you are approved, you will be contacted by the Lighthouse office. The Lighthouse will coordinate your appointments with participating eye specialists and dispensers will contact you. DO NOT SCHEDULE ANY EYE APPOINTMENT OR EYE SURGERIES WITHOUT FIRST NOTIFYING THE LIGHTHOUSE.**
4. **IMPORTANT! Complete the entire application. If a question does not apply to you, do not leave it blank. Write in "N/A" or "0". Failure to answer all questions and obtain necessary signatures may DELAY YOUR APPLICATION FOR UP TO TWO MONTHS.**

1. Applicant's Name: _____
First Middle Last
2. Name of Parent (if applicant is a child): _____
First Middle Last
3. Mailing Address: _____
Street Address (Apt#) City State Zip Code

4. County: _____
5. Sex: (circle) Male Female
6. Date of Birth: ____/____/_____Age:____
7. Social Security Number: XXX – XX – _____
8. Home Phone Number: _____
9. Emergency Phone Number: _____
10. Email Address: _____
11. Do you Work: (circle) Yes or No
12. If no, are you actively seeking employment? Yes or No
13. If applicant does not work, please circle all that apply:
Disabled Not Able Retired Lost Job Other: _____
14. How long have you been a legal Georgia resident? _____
15. Race: (circle) White African American Hispanic Other: _____
16. Are you a Veteran? Circle **Yes** or **No**
17. Do you currently have any **MEDICAL INSURANCE**? Circle **Yes** or **No** (**if yes, please indicate the name of coverage**) _____
18. State reasons why you cannot afford vision care at this time._____
_____
19. Marital Status: (circle) Single Married Divorced Separated Widowed Other

20. List your name and all individuals residing at your address. Please tell us if the individual is your dependent. (A dependent is someone you support financially).
1) Your Name_____
Source of Income_____ Amount of Monthly Income _____
2) Person's Name Living in Your Home _____ Dependent: Yes No
Source of Income_____ Amount of Monthly Income _____

3) Person's Name Living in Your Home_____ Dependent: Yes No
Source of Income _____ Amount of Monthly Income:_____

4) Person's Name Living in Your Home _____ Dependent: Yes No
Source of Income _____ Amount of Monthly Income _____

List total amount of monthly income received by you and all household members. If more than one person receives the same type of income, add the amounts and write in the total:

Supplementary Security Income (SSI)	$_____
Social Security Disability (SSDI)	$_____
Social Security (SS)	$_____
Food Stamps	$_____
Welfare (AFDC)	$_____
Veteran's Benefits (VA)	$_____
Pensions/Retirement Benefits	$_____
Child Support	$_____
Interest/Dividend Investments	$_____
Other Income	$_____
Total Monthly Income (including amounts from jobs)	$_____

ASSETS

Savings, Checking Accounts	$_____
Stocks & Bonds (Market Value)	$_____
Face Value of C.D.'s	$_____
Value of Home/ Land/Property	$_____
Cars/Trucks	$_____
Other Assets:	$_____

MONTHLY EXPENSES

Rent or House Payment	$_____
Telephone	$_____
Utilities	$_____
Food, Medicine	$_____
Car/Truck Payments	$_____
Insurance: Life, Health, Car, Home	$_____
Charge Cards	$_____
Other Expenses	$_____
Total Monthly expenses	$_____
Outstanding Medical Debt	$_____
Outstanding Other Debt	$_____

MEDICAL INFORMATION

1. Have you ever received vision care through the Lighthouse? Yes No If Yes, When?_____
2. Describe your eye condition:
   Right Eye:_____
   _____
   Left Eye:_____
   _____
3. Circle the services you think you need:
   Glasses Artificial Eye Eye Surgery
4. Is your eye condition the result of an injury? Please explain: _____
5. When did your vision problems begin?
   Month_____ Year_____
6. Describe how your visual impairment affects your life:
   _____
   _____
7. When was your last eye exam?
   Month_____ Year_____
8. Who is your eye doctor?
   Name:_____
   Optometrist (O.D.) or Ophthalmologist (M.D.)
   Phone: (_____) _____
   City, State, Zip Code:_____
9. Complete this section if you need eye surgery:
   a. Has a surgery date been scheduled? Yes No
   If yes, When? _____
   b. What type?_____
   c. At what hospital?_____
   d. Surgeon:_____
   Phone(_____)_____
10. Complete this section if you need an artificial eye:
    a. Do you currently wear an artificial eye? Yes No
    b. Name of Ocularist: _____
    Phone:(_____)_____
    City, State, Zip Code:_____
11. If you live in Fulton or Dekalb County, do you have a Grady Card? Yes No If Yes, Grady Card #_____

Applicant Must Read and Sign This Statement:

"I fully understand Lighthouse services are limited to legal Georgia residents unable to pay for, or receive from other sources this assistance. In consideration of these services, I release and discharge all persons rendering such services from any claims I may have arising from services rendered. I am aware that the Lighthouse will not pay for any vision services billed to me prior to approval of this application. I also understand my application may be reviewed by a Lions Club, Lighthouse Providers, and/or the Lighthouse staff. ALL NFORMATION ON AND ATTACHED TO THIS APPLICATION IS TRUE AND CORRECT TO THE BEST OF MY KNOWLEDGE."

_____ _____

Signature of Applicant (or parent if applicant is a child) Witness (if applicant signs with an "X)

MEDICAL RELEASE

This statement MUST be completed and signed by the applicant/parent or guardian:

"I hereby give permission for my medical records to be released to the Lions Club, the Lighthouse, and to any eye specialist, hospital, medical professional, or agency involved with vision care."

_____ _____

Signature of Applicant (or parent if applicant is a child) Witness (if applicant signs with an "X")

AUTHORIZATION FOR RELEASE OF INFORMATION

Applicant should complete this section if you wish for someone other than yourself to contact the Lighthouse about your sight services application.

I hereby request and authorize:_____

(Name of Person or Agency Requesting Information)

_____

(Address)

to obtain from:_____

(Name of Person or Agency Holding the Information)

_____

(Address)

the following type(s) of information from my records (and any specific portion thereof):

_____

for the purpose of:_____

I understand that the Federal Privacy Rule ("HIPAA") does not protect the privacy of information if re-disclosed, and therefore request that all information obtained by this person or agency be held strictly confidential and not be further released by the recipient. I further understand that my eligibility for Lighthouse services is not conditioned upon my provision of this authorization. I intend for this document to be a valid authorization conforming to all requirements of the Privacy Rule and understand that my authorization will remain in effect for: (PLEASE CHECK ONE)

_____ Ninety (90) days unless I specify an earlier expiration date here:_____

_____one (1) year

_____the period necessary to complete all transactions on matters related to services provided to me.

I understand that unless limited by state or federal regulation, and except to the extent that action has been taken based upon it, I may withdraw this authorization at any time.

_____ _____

(Date) (Signature of Individual /Patient/Applicant)

_____ _____

(Signature of Witness) (Title or Relationship) (Signature of other Legally Authorized Representative, where applicable)

USE THIS SPACE ONLY IF AUTHORIZATION IS WITHDRAWN:

_____ _____

(Date this Authorization is revoked by Individual) (Signature of Individual or Legally Authorized Representative)

CASEWORKER/EYE DOCTOR RECOMMENDATION

"I believe_____ is experiencing extreme financial hardship and I recommend

(Name of Applicant)

him/her for assistance from the Lighthouse."

Name and Title:_____ Phone:_____

Agency/Dr.'s Office:_____ Fax:_____

Mailing Address:_____

_____ _____

Signature Date

PLEASE COMPLETE THE ATTACHED QUESTIONNAIRE

Name: _____ Today's Date: _____

Date of birth: _____ Phone number: _____

1. What is your age?
   - ◯ 1-21
   - ◯ 22-34
   - ◯ 35-50
   - ◯ 51-64
   - ◯ 65 & up

2. Are you diabetic or pre-diabetic?
   - ◯ Yes
   - ◯ No

3. Have you ever been diagnosed with any of the following conditions?
   - ◯ Diabetes/pre-diabetes
   - ◯ High blood pressure/hypertension
   - ◯ Obesity
   - ◯ Glaucoma
   - ◯ Cataracts
   - ◯ Macular degeneration
   - ◯ None
   - ◯ Other _____

4. What are you currently doing to manage your diabetes?
   - ◯ Eating healthy and/or seeking assistance from a nutritionist
   - ◯ Taking medication (including insulin)
   - ◯ Physically active at least twice a week
   - ◯ Member of diabetes support group
   - ◯ Participate in diabetes management program
   - ◯ Other (please specify): _____

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5. Are you a student? **If NO, select NO and skip to question 6.**
   - ◯ Yes
   - ◯ No

6. With your current vision, how well are you able to do the following activities?

	Very well	Well	Difficult	Very Difficult	N/A
See the blackboard	◯	◯	◯	◯	◯
Read assignments/books	◯	◯	◯	◯	◯
Use computers	◯	◯	◯	◯	◯
Complete assignments	◯	◯	◯	◯	◯

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7. At this time, how well are you able to do the following activities?

	With a lot of difficulty	With some difficulty	Not sure	With some ease	With great ease	N/A
Be independent	○	○	○	○	○	○
Read prescription on my medications	○	○	○	○	○	○
Write checks, keep up with personal financial matters	○	○	○	○	○	○
Fill out documents of any sort, including employment applications	○	○	○	○	○	○
See objects in the distance	○	○	○	○	○	○
Take care of others (children, spouse, elderly)	○	○	○	○	○	○
Walk around without injury to myself	○	○	○	○	○	○
Drive a car by day	○	○	○	○	○	○
Drive a car by night	○	○	○	○	○	○
Hobbies/social activities	○	○	○	○	○	○
Other (please list the name of the activity in the comment box below)	○	○	○	○	○	○

Other: _____

8. How often do you experience the following symptoms?

	Very frequently	Frequently	Occasionally	Rarely	Never
Blurriness	◯	◯	◯	◯	◯
Floaters (black spots blocking your vision)	◯	◯	◯	◯	◯
Poor night vision	◯	◯	◯	◯	◯
Double vision	◯	◯	◯	◯	◯
Chronic headache	◯	◯	◯	◯	◯

9. At the present time, how would you describe your overall vision (before eye surgery)?

◯ Excellent
◯ Good
◯ Fair
◯ Poor
◯ Very poor
◯ Completely blind

10. What is the best description of your current employment?

◯ I don't work
◯ Employed
◯ I am currently not seeking employment
◯ Seeking employment
◯ In rehabilitation program
◯ Student
◯ Retired
◯ Disabled
◯ Other (please specify)
Comment: _____

11. How often do you rely on aid/assistance from friends and family?

◯ Very frequently
◯ Frequently
◯ Occasionally
◯ Rarely
◯ Never
Comment: _____

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Medicaid/Medicare Affidavit

I, _____, (full printed name) declare under penalty of perjury that the following is true and correct to the best of my knowledge, information, and belief.

1. I confirm that I have lived in the State of Georgia as of_____(Date)
   - Current Home Address: _____
   - Current Home Number: _____

2. I confirm that I do **not** have Medicaid and Medicare at this time: YES or NO (Circle One)

A copy of this affidavit is being filed with Georgia Lions Lighthouse Foundation (GLLF), in the designated Vision Surgery Program electronic patient filing system. Patient information will be kept on record for a minimum of three years. The GLLF accepts this affidavit in good faith.

Patient acknowledges that a copy of this contract has been made available per their request. Patient also agrees to reimburse physician for any costs and reasonable attorney's fees that result from violation of this agreement by the patient or his/her beneficiaries.

Patient Print Name: _____

Patient Sign Name: _____

Date:_____

GLLF Representative Print Name: _____

GLLF Representative Sign Name: _____

Date:_____