LIONS EYE BANK OF DISTRICT 2T-1, INC

APPLICATION FOR PAYMENT TOWARD SIGHT SAVING SURGERY

INDEX OF FORMS NEEDED

LIONS EYE BANK OF DISTRICT 2T-1, INC

APPLICATION FOR PAYMENT TOWARD SIGHT SAVING SURGERY

Form # 1 – Instruction Sheet

IMPORTANT – READ CAREFULLY AND PLEASE FOLLOW INSTRUCTIONS

DO NOT PROCEED with surgery or hospitalization **BEFORE** receiving the ~ **Official LIONS EYE BANK OF DISTRICT 2T-1, INC. Authorization** signed by an authorized OFFICER, or in

EMERGENCY CASES~ IMPORTANT: Telephone the Lions Eye Bank of District 2T-1, Inc. or its President for authorization for surgery and hospitalization.

QUALIFICATIONS: The applicant (if a minor, parent or guardian) **MUST** be unable to pay for the surgery and hospitalization and **MUST** come within the scope of our financial eligibility requirements.

PROCEDURE:

1. Every application **MUST** be submitted and approved by the Eye Bank Board.
2. Every application **MUST** not have any blanks, and for anything that doesn't apply put N/A.

RESTRICTIONS:

1. Patient **MUST** have LEGALLY resided in the U.S.A. for a period of not less than 1 year and does not have adequate insurance.

NO BILL WILL BE PAID UNTIL FORM 6 ~ Official LIONS EYE BANK OF DISTRICT 2T-1, INC. Authorization IS ISSUED, BEARING AN AUTHORIZED SIGNATURE OF AN OFFICER OF THE LIONS EYE BANK OF DISTRICT 2T-1, INC. Payment will be made to the Surgical Center only.

Form #2 – Application for Sight Saving Surgery and Hospitalization Assistance

Please answer EVERY QUESTION: (If it does not apply, mark "no" or "none"). If the applicant is a minor or is living with and or supported by parents, data required pertains to both the parent(s) and applicant.

1. Name of applicant_____
2. Age_____
3. If minor, name of parent(s) or guardian(s)_____
4. Name of Employer_____
5. Dates of employment; from _____to_____
6. Own business? _____ Net Worth $_____ Kind_____ Wages _____Draws_____
7. If No income, how are you supported? _____
8. Are you registered with the Medicare/Medicaid Programs to cover the doctor's fees? YES_____ NO_____ or Hospital fees? YES_____ NO_____
9. If question 8 is yes, do you have supplemental Insurance YES_____ NO_____

INCOME RECEIVED ANNUALLY

10. Salary of Husband ~ Net $_____
11. Salary of Wife ~ Net $_____
12. Salary of Parent(s) or Guardians(s) $_____
13. Social Security $_____
14. Other Income $_____
15. TOTAL NET INCOME (Annually) $_____
16. Number of dependents on income above: $_____

LIST ANY UNUSUAL OR EXTENUATING CIRCUMSTANCE:

TOTAL NET ASSETS: $_____

FORM #2 ~ APPLICATION FOR SIGHT SAVING SURGERY AND HOSPITALIZATION ASSISTANCE

NOTE: PLEASE, ALL QUESTIONS MUST BE ANSWERED.

APPLICANT MUST BE INTERVIEWED BY A MEMBER OF THE DISTRICT 2T-1 EYE BANK BOARD.

PLEASE PRINT OR TYPE:

1. Name of applicant in full _____

   First Middle Last

   Social Security Number_____

2. Residence of Applicant _____

3. Sex_____Age_____Birth Date_____ Married or Single_____

4. Name of Parent of Guardian if applicant if a minor_____

5. Has previous application been made for treatment or hospitalization to the Lions Club Eye Bank of District 2T-1, Inc? _____Yes/ No_____

Form #3 - AGREEMENT OF APPLICANT (PARENT OR GUARDIAN IF A MINOR)

Applicant is hereby made for surgery and hospitalization for the above applicant. I agree for myself an applicant (parent or guardian if a minor) to abide by all the rules and regulations as defined by the Board of Directors of the Lions Eye Bank of District 2T-1, Inc.

Accordingly, I hereby certify that a reasonable effort has been made to secure financial assistance from other possible sources of aid, including tax-supported agencies.

I am not able to pay for surgery or hospitalization of myself (or applicant if a minor) and understand the surgery will be financed by the Lions Eye Bank of District 2T-1, Inc. I hereby absolve the Lions Eye Bank of District 2T-1, Inc. of ANY responsibility in connection with the surgery or hospitalization of myself (or applicant if a minor). I understand their obligation is limited to the financing of such surgery only as agreed to by me (parent or guardian is a minor) and authorized by the Lions Eye Bank of District 2T-1, Inc. I also agree that any money I receive from Welfare, Medicare or ANY insurance, is to be applied toward payment of ANY bills incurred by me, (or applicant if a minor) pertaining to eye surgery and hospitalization for the surgery.

In the event applicant is a ward, this agreement is to signed by a guardian. A copy of the Court Order authorizing such appointment must be submitted with application.

I certify that the above information and data of this application ~ **Application for Sight Saving Surgery and Hospitalization Assistance,** is to the best of my knowledge and belief, a correct and true statement.

I also certify that I have been a **LEGAL** resident of the U.S.A. for a period of not less than one year.

6. Date_____

7. Witnessed By_____
(Must Be An Eye Bank Board Member)

8. Address of Witness_____
Street

_____

City State Zip

9. Signed_____
Applicant (Parent or Guardian if a minor)

10. Address of Applicant_____
Street

_____

City State Zip

FORM #4 **Or**

AUTHORIZATION IS GIVEN BY TELEPHONE DIRECTLY FROM THE PRESIDENT OR VICE PRESIDENT OF THE LIONS EYE BANK OF DISTRICT 2T-1, INC.

OTHERWISE,

THE LIONS EYE BANK OF DISTRICT 2T-1, INC IS NOT RESPONSIBLE FOR ANY EXPENDITURES.

IF ANY PART OF SURGERY OR HOSPITALIZATION IS ASSUMED BY WELFARE, UNIONS, INSURANCE OR MEDICARE/MEDICAID, SAME SHOULD BE DEDUCTED FROM AMOUNT AUTHORIZED BEFORE BEING PRESENTED FOR PAYMENT. ATTENCING OPHTHALMOLOGIST IS TO COMPLETE PART A; HOSPITAL OR FACILITY IS TO COMPLETE PART B; ANESTHETIST IS TO COMPLETE PART C. PLEASE ANSWER EVERY QUESTIONS, OTHERWISE FORMS WILL BE RETURNED, THU CAUSING A DELAY.

PART A Date___/___/___

Patient's Name:_____Sex:_____Age:_____

Address:_____City:_____State:_____Zip:_____

Has the patient had any incurable malady such as Diabetes, etc...affecting the eyes? YES____ NO_____

1. DIAGNOSIS:_____
2. TYPE OF SURGERY RECOMMENDED:_____
3. APPROXMATE DATE RECOMMENDED FOR SURGERY: ____/____/____
4. PREVIOUS TREATMENT FOR THIS CONDITION:_____
5. Doctor's fee, including examinations, surgery, post-operative care and refraction, as per our schedule.

   Doctor's Office Phone Number: (___) _____-_____. Doctor's Fax Number: (___) ____-_____

   Doctor's fee to be waived to research? YES_____ NO_____

   Doctor's Name:_____,M.D.

   Address:_____City_____State_____Zip_____

6. IS THE PATIENT COVERED BY MEDICARE? YES_____ NO____ (Check One). PLAN A____ or PLAN B____
7. ARE OTHER KNOWN SOURCES OF AID AVAILABLE: YES_____ NO___ (Check One). IF SO, PLEASE DESCRIBE:

I HEREY AGREE TO ACCEPT PAYMENTOF $2000 FROM THE LIONS EYEBANK OF DISTRICT 2-T1 AS PAYMENT IN FULL.

DOCTOR'S SIGNATURE:_____M.D. Date____/____/____

FORM #4 – DOCTOR TO COMPLETE

CERTIFICATE OF SURGICAL PROVIDERS

PART B

10. FACILITY'S FEE AS PER OUR SCHEDULE.

NAME:_____

ADDRESS_____CITY_____STATE_____ZIP_____

THIS INSTITUTION DOES HERBY AGREE TO ACCEPT AUTHORIZATION AS PAYMENT IN FULL.

SIGNATURE:_____ Title:_____Date:___/___/_____

PART C

11. ANESTHETIST'S FEE, AS PER OUR SCHEDULE.

NAME_____CITY_____STATE_____ZIP_____

ADDRESS:_____CITY_____STATE_____ZIP_____

I HEREBY ACCEPT AUTHORIZATION AS PAYMENT IN FULL.

SIGNATURE:_____Title_____Date:____/____/_____

FORM #5 - EYE BANK BOARD MEMBER TO COMPLETE

Remarks or Recommendations:

I certify as an Eye Bank Board Member, to the best of my knowledge and through personal interview with the applicant, the above information is correct and I recommend the applicant.

_____(signature)

FORM #5

SIGHT SAVING EYE SURGERY FOR

_____of _____recommended

(Name of Applicant) (City, State)

By the _____of_____.

(Eye Bank Board Member) (City, State)

Such reimbursement or direct payment to the doctors/hospital charges will be forwarded to the Lions Club Eye Bank of District 2T-1, Inc, P.O. Box 19293, Amarillo, TX 79114, prior to the funds being disbursed.

After a brief review of these charges by the Board, the authorized funds will be forwarded to the appropriate party.

LIONS CLUB EYE BANK OF DISTRICT 2T-1, INC.

BY_____

(President/Vice President/Treasurer)

WITNESSED BY:

_____

(Eye Bank Board Member)