Lions of Wyoming Grant Application
COVER SHEET
To be completed by sponsoring Lions Club

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 LoWF payment is 50% of Medicare Rate)
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 LoWF Exec. Dir._____

Payment for surgery should be sent to:

Director_____ Sponsoring Lions Club_____

Date Submitted: _____ Date Approved: _____

Motion: _____ Second: _____

LoWF 06/19/18

Lions of Wyoming Foundation (LOWF)
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 LOWF 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? _____

Applicant _____

Lions of Wyoming Foundation (LoWF)

Consent Form

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 LoWF and its agents of any responsibility for injury or mistreatment in connection with any procedure or surgery funded by LOWF.

I further absolve LOWF 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 LOWF now and in perpetuity for public and medical education.

I authorize the use and disclosure by LoWF 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, LOWF Board of Directors, LoWF 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:

* LOWF Board of Directors
* Members of _____Lions Club
* Employees of the Lions of Wyoming Foundation
* Health care providers
* Other _____

This information is being disclosed for the purpose of determining whether, and to what extent, LOWF and the LOWF 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 LOWF's office at 224 Talon Ct., Cheyenne, WY 82009.

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_____

Lions of Wyoming Foundation (LoWF)
MEDICAL PORTION
Certification of Medical Need and Fees by Ophthalmologist

Please Note: LOWF will not assume any financial responsibility prior to issuance of an authorization on LOWF 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**. LOWF-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

Applicant _____

Lions of Wyoming Foundation (LOWF) Grant 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 LOWF Grant $_____

   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 Lions of Wyoming. If you have any questions, please contact Lion David Orr (307-222-8460) or email at liondave@lionsofwyoming.org.

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: _____