



**ROCKY MOUNTAIN LIONS EYE BANK
EYE SURGERY GRANT APPLICATION
COVER SHEET**

**To be completed by sponsoring Lions Club/Responsible Lion
(See separate attachment for Application Qualifications and Procedures)**

(This form must be used for all applications on or after 7/09/21)

Applicant's Name _____ Age _____

Sponsoring Lions Club _____

Responsible Lion: Name _____
Street Address _____
City _____ State _____ Zip _____
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 ESG grant amount is 80% of Medicare rates)

Requested Amount from the Eye Surgery Grant _____

Amount from the sponsoring Lions Club _____

Amount from other source or patient _____

TO BE COMPLETED BY THE RMLEB BOARD DIRECTOR
Application reviewed and presented by RMLEB Board Director _____

Payment for surgery should be sent to:

Director _____ Sponsoring Lions Club _____

Date Submitted: _____

Date Approved: _____

Motion: _____

Second: _____

Rocky Mountain Lions Eye Bank (RMLEB) Eye Surgery Grant Application
APPLICANT PORTION
Lions Club Interview with Applicant to Determine Financial Need

1. Applicant Name _____
First Last

2. Address _____
Street 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 RMLEB Eye Surgery Grant? Yes No
 If yes, describe circumstances _____

11. Is applicant a U.S. citizen? Yes No

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? Yes No
 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.? Yes No
 If yes, provide agency name and decision. _____

18. Does applicant have insurance? (Medicare/Medicaid are government insurance) Yes No
 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? Yes No

**Rocky Mountain Lions Eye Bank (RMLEB) Eye Surgery Grant Application
APPLICANT PORTION (CONT.)**

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 RMLEB and its agents of any responsibility for injury or mistreatment in connection with any procedure or surgery provided by a grant by RMLEB.

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

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

- * RMLEB Board of Directors
- * Members of _____ Lions Club
- * Employees of the Rocky Mountain Lions Eye Bank
- * Healthcare providers
- * Other _____

This information is being disclosed for the purpose of determining whether, and to what extent, the RMLEB Board of Directors may be able and willing to provide financial assistance to the applicant for treatment and care.

I understand I do not have to sign this authorization and may revoke it at any time and in order to do so, I must do so in writing and send to: Rocky Mountain Lions Eye Bank

1675 Aurora Court, Mail Stop F751
Aurora, CO 80045

I understand the revocation will not apply to information that has already been released pursuant to this authorization.

I understand 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 _____

**Rocky Mountain Lions Eye Bank (RMLEB) Eye Surgery Grant Application
MEDICAL PORTION**

Certification of Medical Need and Fees by Ophthalmologist

Please Note: RMLEB Board of Directors will not assume any financial responsibility prior to issuance of an authorization on RMLEB letterhead with the signature of the Chair of the ESG Committee. Eye Surgery Grants 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**. The ESG 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. Disease(s) affecting the eye(s) _____
5. Type of surgery needed _____

Left eye (OS) Right eye (OD) Both eyes (OU) Other _____

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 timeframe for each surgery _____

Anticipated number of surgical facility admissions needed _____

Facility Name _____

Address _____ City _____ State _____ Zip _____ Phone _____

Anesthesiologist Name _____

Address _____ City _____ State _____ Zip _____ 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,				
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 _____

**Rocky Mountain Lions Eye Bank (RMLEB) Eye Surgery 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 RMLEB Eye Surgery 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 _____

Responsible Lion of Sponsoring Club _____ Date _____

Signature of Responsible Lion _____

**Rocky Mountain Lions Eye Bank
Eye Surgery Grant Verification of Surgical Treatment
For Reimbursement of Services**

The Rocky Mountain Lions Eye Bank Eye Surgery Grant Committee requires verification of surgical treatment before funds from the Eye Surgery Grant can be paid.

Once surgery has occurred, please mail completed form to:

Rocky Mountain Lions Eye Bank
attn: Lion Betsy Bohanna
1675 Aurora Court, Mail Stop F751
Aurora, CO 80045

or fax to: 720-848-3938

If you have any questions, please contact the Eye Surgery Grant Committee Chair, PDG John Ballagh: 970-208-5849 or jballagh@gmail.com

Patient name: _____

Surgeon name: _____

Address: _____

Contact person name: _____ Phone: _____

Date of Surgery: #1 _____

Date of Surgery: #2 _____

Cost of Treatment: _____

(Total expenses including surgeon, surgery center and anesthesiologist.)

Surgeon's Signature: _____

Date Sent: _____