

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

**To be completed by sponsoring Lions Club**

**(See separate attachment for Application Qualifications and Procedures)**

(This form must be used for all applications on or after 7/09/16)

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 ESF grant amount is 60% of Medicare rates)  
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 District Eye Bank 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 Fund Application**  
**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 RMLEB 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? \_\_\_\_\_

**Rocky Mountain Lions Eye Bank (RMLEB) Eye Surgery Fund 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 funded 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

\* Health care providers

\* Other \_\_\_\_\_

This information is being disclosed for the purpose of determining whether, and to what extent, RMLEB and the RMLEB 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 RMLEB's office at the Rocky Mountain Lions Eye Institute Building at 1675 Aurora Ct, F751, Suite #E1-2049, Aurora CO 80045-0358.

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 \_\_\_\_\_

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

**Certification of Medical Need and Fees by Ophthalmologist**

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

**Rocky Mountain Lions Eye Bank (RMLEB) Eye Surgery Fund 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 Fund \$ \_\_\_\_\_

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 Rocky Mountain Lions Eye Bank, 1675 Aurora Court, MSC F751, Aurora, CO., 80045, (fax) 720-848-3938. If you have any questions, please contact Lion Carole Kitchell, 970-484-9012 or email at [c.t.kitchell@usa.net](mailto:c.t.kitchell@usa.net)**

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: \_\_\_\_\_