LIONS DISTRICT 26–M2 EYECARE COMMITTEE - REFERRAL FORM

Referred by _____ Date _____
Address _____ Telephone (__)_____
City _____ State _____ Zip code _____

PLEASE ANSWER ALL QUESTIONS

Name _____ Telephone (____) _____
Address _____ City _____ State _____ Zip _____
Date of Birth: Month _____ Date ____ Year _____ Sex _____ Race_____ Marital Status_____
(If applicant is less than 18 years of age, parent or guardian must complete and sign form.)

Social Security # _____ Driver's License # _____
For Minor-Parent/Guardian Name _____ Relationship to Minor _____
For Adult – Emergency Contact Name _____ Telephone (____) _____
Brief Description on Problem _____

TOTAL MONTHLY INCOME		**TOTAL MONTHLY EXPENSES**	
Wages	_____	Rent/Mortgage	_____
Pension	_____	Gas & Electric	_____
Unemployment	_____	Telephone	_____
Social Security/SSI	_____	Medical	_____
Food Stamps	_____	Clothing	_____
Housing Allowance	_____	Food	_____
Other	_____	Other	_____
TOTAL INCOME	**_____**	**TOTAL EXPENSES**	**_____**

Number of persons living in household _____

(For surgery requests, please attach copy of both sides of current Federal Income Tax Return (1040) and/or most recent Social Security Benefit Amount Notification Letter along with copy of any other monthly income.)

Is applicant covered by medical insurance? Yes ____ No ____ (If yes, supply information below.)
Entitled to Medicaid? Yes ____ No ____ DCN # _____
Entitled to Medicare? Yes ____ No ____ ID # _____
Other Insurance: _____ Name of Insured if different from applicant: _____
Has assistance from Government Agencies been sought? Yes ____ No ____ If yes, please list agencies applied to and determination of eligibility: _____Attach copy of letters.

AGREEMENT
I understand that Lions Eyecare Committee will cover expenses for examination, treatment or surgery only after acceptance of referral. I certify that all the information above is correct and that deliberate misrepresentation may cause me to be declined for the applied aid. I acknowledge I have read and signed attached disclosure form.

Applicant's Signature _____ Date _____

Send Completed form to:

Lions Eyecare Committee
1695 Valero
Fenton, MO 63026

FOR OFFICE USE ONLY:
Application Accepted: Yes ____ No ____
Referred to: _____
For Service/Exam _____
CASE FILE # _____

LIONS DISTRICT 26-M2 EYECARE COMMITTEE

I, _____, hereby authorize the Lions District 26-M2 Eyecare Committee to release any information regarding my application for medical and financial history to the Lions Eyecare Committee members for their review, if so requested.
Also, Lions District 26-M2 Eyecare Committee, affiliated Lions Clubs and medical consultants are indefinitely released from all debts, claims and/or liability of any kind arising out of or in connection with the use or description of this informational material.

Applicant or Parent/Guardian Signature _____
Date _____

I give permission to the Lions Eyecare Committee to leave messages at my home or work containing information regarding appointments, surgeries, glasses, contacts, or results of medical testing.

Yes ____ No ____

I also give permission to discuss any of my personal or medical information to the person(s) listed below. If no names are listed, I understand that no information will be given other than the brief messages listed above. I have the right to change this decision at any time with written or verbal notice to Lions District 26-M2 Eyecare Committee.

Specific person(s) permitted to discuss detailed information.

_____

_____

_____

Applicant or Parent/Guardian Signature _____
Date _____

CASE FILE # _____