



## **Eye Surgery Fund-Application Procedure** (For sponsoring Lions Clubs only)

**The Rocky Mountain Lions Eye Bank (RMLEB)** is proud to be able to work cooperatively with **Lions Clubs** and **Ophthalmologists** throughout Colorado and Wyoming to support eye surgery for residents who are financially unable to obtain medical treatment. The Rocky Mountain Lions Eye Bank Eye Surgery Fund (ESF) works in combination with donations from the local Lions Club as well as Ophthalmologists and surgical facilities willing to provide discounted services to patients with demonstrated financial need and no insurance. Lions Clubs wishing to sponsor a patient for ESF consideration should send the completed application to their District Eye Bank Director or the Chair of the ESF Committee.

**Qualifications:** The applicant (parent/guardian) **MUST** be unable to pay for eye surgery, have no insurance, and not be qualified for other assistance such as Medicare or Medicaid. The ESF is for **SIGHT-SAVING SURGERY ONLY**.

### **Application:**

**Part 1-** Determines the applicant's eligibility. The Responsible Lion from the local Lions Club will interview the applicant to complete the first part of the application. The applicant must have pursued all available existing support such as Welfare, SSI, Medicare, Veterans benefits, etc. The Responsible Lion will complete this portion of the application. The applicant must sign the Indemnification and Consent for Use and Disclosure of Personal and Health Information

**Part 2-** Determines the sponsorship of the applicant by the local Lions Club. The Responsible Lion will complete a brief history of association with the applicant. Since this is a cooperative effort, some financial assistance is requested from the local Lions Club. The final portion of part 2 identifies the Responsible Lion within the local Lions Club to oversee the complete process.

**Part 3-** Certifies medical need. The Responsible Lion works with the applicant and ophthalmologist to complete the Certification of Medical Need. The surgeon, surgical facility and anesthesiologist must be willing to discount or waive their fees. Help in completion of any part of the ESF application is available from the District Eye Bank Director or the Chair of the ESF Committee.

Your Director is: Name \_\_\_\_\_ Phone \_\_\_\_\_  
Current Chair of the ESF Committee is: PDG Eileen Sanderson Phone: 719-269-8274  
1111 Macon Ave. Fax: 719-269-1180  
Cañon City, CO 81212 Email: [eileens@cpubroadband.net](mailto:eileens@cpubroadband.net)

If neither of these sources are available, send or fax the application to the Rocky Mountain Lions Eye Bank c/o Lion Ed Jacobs, Executive Director.

If **EMERGENCY** surgery is medically required, contact your Director immediately.

**Process:** Once the application is completed, deliver the application to the District Eye Bank Director. The application will be reviewed at the bi-monthly RMLEB board meeting. Following the RMLEB bi-monthly board meeting:

- 1- The District Eye Bank Director will notify the Responsible Lion regarding the status of the application.
- 2- Notification of the board's decision will be mailed to the Responsible Lion (copy to District Eye Bank Director).
- 3- Once the application is approved, the Responsible Lion will notify the applicant and the surgeon.

**Payment:** Once the surgery is complete;

- 1- The surgeon must send the Verification of Surgical Treatment form to the ESF Committee Chair.
- 2- Upon completion, the Responsible Lion will notify the District Eye Bank Director.
- 3- Funds will be mailed to the Responsible Lion (whose address appears in part 2) or to the District Eye Bank Director for presentation to the sponsoring Lions Club.
- 4- The sponsoring Lions Club will deliver funds to the surgeon for payment of RMLEB approved medical treatment.



**ROCKY MOUNTAIN LIONS EYE BANK  
EYE SURGERY FUND 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) \_\_\_\_\_  
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 \_\_\_\_\_

# Rocky Mountain Lions Eye Bank (RMLEB) Eye Surgery Fund Application

## Part 1- Lions Club Interview with Applicant to Determine Financial Need

### Consent for Use and Disclosure of Personal and Health Information

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? \_\_\_\_\_ If not, when was application for citizenship made? \_\_\_\_\_

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 towards 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? \_\_\_\_\_

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)

\$ \_\_\_\_\_

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	\$ _____

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? \_\_\_\_\_

# 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 N. Ursula Street, Suite #E12049, Aurora, Colorado 80010 or received by RMLEB at its Post Office Box 6026, 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 (ie. 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

## Part 2 - 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. Amount your Lions Club donated to RMLEB this fiscal year \$ \_\_\_\_\_

6. Financial assistance needed from the RMLEB Eye Surgery Fund \$ \_\_\_\_\_

7. Financial assistance from sponsoring Lions Club \$ \_\_\_\_\_

8. Amount applicant is able to pay toward surgery costs \$ \_\_\_\_\_

9. Total of items 6+7+8 \$ \_\_\_\_\_

10. Total Discounted Cost from Part 3 \$ \_\_\_\_\_

11. If #10 is greater than #9, list source of additional funding? \_\_\_\_\_

\_\_\_\_\_

12. Sponsoring Lions Club \_\_\_\_\_

Signed \_\_\_\_\_

Responsible Lion of Sponsoring Lions Club

Date \_\_\_\_\_

Print name \_\_\_\_\_

Address \_\_\_\_\_

Phone \_\_\_\_\_

Home

Work

Email \_\_\_\_\_





## 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.

**Please mail or fax completed form to Director Eileen Sanderson 1111 Macon Avenue, Cañon City, CO 81212, fax 719-269-1180 once surgery has occurred. If you have any questions please contact Director Eileen Sanderson at 719-269-8274.**

Patient Name: \_\_\_\_\_

Surgeon Name: \_\_\_\_\_

Address: \_\_\_\_\_

\_\_\_\_\_

Date of Surgery: \_\_\_\_\_

Cost of Treatment: \_\_\_\_\_

Surgeon's Signature: \_\_\_\_\_

Date: \_\_\_\_\_