

Lions of Wyoming Grant Application Form

INSTRUCTION FOR COMPLETING PATIENT EYE CARE APPLICATIONS:

It is vitally important that a club applying for assistance (FROM THE PATIENT EYE CARE PROGRAM OF THE LIONS OF WYOMING FOUNDATION) thoroughly screen the individual patients. This is important whether the club is applying for either a matching grant or a matching grant with a loan. The screening should include a complete review of the financial background of the applicant or if the patient is a minor review of the financial resources of the parents/guardians.

The attached application is an aid in determining the resources of the individual or family. **It must be completed and returned to the Foundation office with the club application.** *A personal, one-on-one interview with the patient in his or her home is ideal.* Some applicants may have the personal ability to pay, or be covered by health insurance, Medicare or Medicaid. It is necessary to be completely certain that there is a bona fide need and an inability to pay by the patient requesting assistance. **The Patient Eye Care Program of the Foundation, in conjunction with a club should always be the “last resort”.**

Once the club has determined that the family has exhausted all means of payment, an application to the Lions of Wyoming Foundation can be made. **When this is determined, be sure to ask the physician, hospital and all providers of medical care if they will waive or discount their normal fees.**

After reading these instructions carefully, please work with the applicant, the medical providers and your club to complete the forms completely before sending them in to the Foundation office.

If additional information is required, please refer to the Policy Manual, page 31.

Lions of Wyoming Foundation

GRANT APPLICATION – Part 1

(To be filled out by the person requesting assistance)

PLEASE PRINT OR TYPE

TO: _____ Lion/Lioness Club

Patient's Name: _____

If a Minor, Name of Parents/Guardians: _____

Address: Street: _____ City: _____

State: _____ Zip: _____

Phone: _____

Occupation: _____ Monthly Income: _____

Spouse's Occupation: _____ Monthly Income: _____

Other Income: _____ Savings: _____

Source: _____ Monthly Amount: _____

QUALIFICATIONS:

HEALTH INSURANCE: _____ YES _____ NO

MEDICARE: _____ YES (PART A _____ PART B _____)

_____ NO

MEDICAID* _____ YES _____ NO

*We will accept Medicaid if qualified: _____ YES _____ NO

V.A. ELIGIBILITY _____ YES _____ NO

MONTHLY EXPENSES:

House Payment or Rent: \$ _____

Car Payment: \$ _____
Make/Model, Year _____

Recreational Vehicle (Boat, RV, ATV, ETC.)
Type _____ Value \$ _____

Other Expenses:
Lights, Heat, Telephone \$ _____

Insurance: \$ _____

Food Budget: \$ _____

Other:

TOTAL: \$ _____

OTHER INFORMATION:

**THE INFORMATION PROVIDED HERE IS CORRECT AND TRUE.
WE ATTEST TO THE ACCURACY:**

Patient' s Signature

Parent/Guardian' s Signature (if patient is a minor)

Spouse' s Signature

Lions of Wyoming Foundation
GRANT APPLICATION – Part 2
(To be filled out by sponsoring Lions Club)

DATE: _____

NAME OF CLUB SUBMITTING APPLICATION: _____

CLUB ADDRESS:

Street: _____

City: _____ State: _____ Zip: _____

CONTACT LION: _____

Street: _____

City: _____ State: _____ Zip: _____

PHONES: _____

Day

Evening

Fax

PATIENT' S NAME: _____

ADDRESS: Street: _____

City: _____ State: _____ Zip: _____

Phone: _____

IF A MINOR, NAME OF PARENTS/GUARDIANS: _____

PATIENT' S VISUAL PROBLEM: _____

MEDICAL TREATMENT REQUESTED SECTION:

PATIENT'S DOCTOR: _____

ADDRESS: Street: _____

City: _____ State: _____ Zip: _____

Phone: _____

To be filled out by Treating Physician:

PHYSICIAN'S DIAGNOSIS:

RECOMMENDED TREATMENT:

TREATMENT COSTS:

ORIGINAL ESTIMATED COSTS:

DISCOUNTED QUOTES:

Doctor _____

Hospital _____

Anesthetist _____

Other _____

Total Estimated Costs After Discounts:

\$ _____

CLUB CERTIFICATION

OUR LION/LIONESS CLUB HAS DETERMINED THE FOLLOWING:

- _____ The patient/guardian/parent does not have sufficient financial resources
- _____ The patient/guardian/parent is not on public assistance.
- _____ The patient/guardian/parent does not have adequate insurance to provide the treatment nor is he/she covered by Medicare or Medicaid.
- _____ Our Board of Directors has reviewed the Policies and Guidelines and agrees to abide by them.

PAYMENT OPTION REQUESTED:

_____ **OPTION A:** A joint venture with the Lions of Wyoming Foundation and our Lion/Lioness Club each paying 50%. The Foundation will make their half of the payment directly to the vendors upon receipt of copies of the bills.

_____ **OPTION B:** The costs will be paid by the Lions of Wyoming Foundation, upon receipt of the bills from the providers. Fifty percent will be considered a matching grant and the remaining 50% will be considered an interest free loan that will be paid back to the Foundation in the following manner:

SIGNED: _____
President of Sponsoring Lion/Lioness Club

SIGNED: _____
Secretary of Sponsoring Lion/Lioness Club

ADDITIONAL INFORMATION OR COMMENTS:

Please mail all forms/information to:

**Executive Director
Lions of Wyoming Foundation
224 Talon Court
Cheyenne, WY 82009**

If you have any questions, please call: 307.778.8568