Lions Eye Foundation (LEF) of California-Nevada, Inc.
P.O. Box 7999
San Francisco, Ca 94120

Mission: To preserve and restore the gift of sight by providing free ophthalmic examinations, operations, and medication to the less fortunate members of our community.

Who receives services and eligibility?

Members of the community who are served through LEF

- Over 18 yrs of age- proof of one year's continuous residency within LEF community and legal residency
- Under 18 yrs of age- proof of one year's continuous residency within LEF community*
- Patients with NO insurance/coverage for eye surgical care.
- Income (this is based on NET INCOME)

Single Person/Married Couple	$22,800
Single Parent/Parents with One Child	$25,300
Single Parent/Parents with Two Children	$27,600
Single Parent/Parents with Three Children	$30,000

Add $2,400 for each additional child

What LEF does?

Offers free

- Ophthalmic examinations
- Operations
- Medication
- Provide glasses after patient has complete treatment/surgery
- Complete Financial Statement, and
- Patient Referral Form

When can a patient receive services?

With proof of a Doctors Referral that determines a patient's need for eye treatment and care. (Excludes eye glasses and contact lenses)

Where can a patient receive services?

The patient receives all serves at the San Francisco Office; money for transportation to and from appointments is provided by LEF.

Questions or Emergency cases:

Call/contact Mark Paskvan at
Tel. (415) 600.3950
Fax (415) 600.3949
E-Mail: paskvam@sutterhealth.org

*Santa Cruz County is a community served by LEF.

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P.O. Box 7999
San Francisco, CA 94120

PRESERVING THE GIFT OF SIGHT

QUICK LIST FOR REFERRING PATIENTS

1. Patient Eligibility

   - If over 18 years of age – one year's continuous residency in the communities served by the LEF **AND** must be a legal resident of the United States.

   - Under 18 years of age – one year's continuous residency in the communities served by the LEF.

   - Income (this is based on NET INCOME)

Single Person/Married Couple	$22,800
Single Parent/Parents with One Child	$25,200
Single Parent/Parents with Two Children	$27,600
Single Parent/Parents with Three Children	$30,000
Add $2,400 for each additional child	

   - Patient has no insurance/coverage for eye surgical care.

2. Doctor Referral

   - It must first be determined that the patient does indeed have an eye problem that requires treatment and care (excluding eye glasses and contact lenses). A referral from a doctor stating the patient's diagnosis is required.

3. Club's Responsibility

   - Completion of patient financial statement and patient referral form (must be signed by doctor, patient and club representative).

   - Provide money for transportation to and from appointment in San Francisco.

   - Provide glasses after patient has completed treatment/surgery.

4. Questions: Call/contact Mark Paskvan tel (415) 600-3950; fax (415) 600-3949;
   e-mail paskvam@sutterhealth.org.

   - Emergency cases (retina detachments and foreign object in eye), call Mark rather than completing the forms. It can be done by phone!

The Lions Eye Foundation of California-Nevada, Inc. preserves and restores the gift of sight by providing free opthalmic examinations, operations, and medication to the less fortunate members of our community.

PATIENT FINANCIAL STATEMENT AND APPLICATION
FOR EYE CARE AND TREATMENT THROUGH SPONSORSHIP OF THE

Lions Eye Foundation of California – Nevada, Inc.

MAILING ADDRESS: P.O. BOX 7999, SAN FRANCISCO, CA 94120

(revised 1/1/93)

Patient's Name: ______________________________ Telephone: (___)______________

Address: ______________________________ Date of birth: ______________

Sex: M __________ F __________

If patient is a minor, the following information refers to parent or guardian:

Dependents: Name, Age, Relationship

1. ______________________________

2. ______________________________

Dependents: Name, Age, Relationship

3. ______________________________

4. ______________________________

Financial Information of Patient or Responsible Party:

1.Cu rrent Employment:
Name of Employer: ______________________ Telephone: (___)______________
Address: ______________________ Your Driver's Lic. #: ______________
How long Employed: ______________________ Soc. Sec. #: ______________

2.Spous e Employment:
Name of Employer: ______________________ Telephone: (___)______________
Address: ______________________ Your Driver's Lic. #: ______________
How long Employed: ______________________ Soc. Sec. #: ______________

3.If U nemployed, how long since you have worked: ______________________

4.If Ret ired, date of retirement: ______________________

5.Mont hly Income:
Source: Salaries and Wages ______________________ Gross Amount: __________
Source: ______________________ Gross Amount: __________
Total Gross Income: ______________________ $ __________
Total Net Income: ______________________ $ __________
If Self Employed: Net taxable income: ______________________ $ __________
After Tax Net income: ______________________ $ __________

6.Li st of Amounts Owed:
To Whom: Amount
____
____
____

Total Amount Owed: .... $ __________

7.Pa tient has been at current address how long? _______ if less than one year, please list prior addresses and length of residence at each for the past year. ______________________
____
____

8. A. Citizenship of applicant ______________________
B. If not U.S. citizen, are you a legal resident? ______________________
Type of visa or card ______________________ Exp. Date __________

8. List of Assets:

A. Market Value of Home: $ ____________________
   Less Amt. Of Mortgage owed: $ ____________________
   Net Value $ ____________________

B. Other Real Estate Owned: $ ____________________
   Less Amt. Of Mortgage Owed: $ ____________________
   Net Value .... $ ____________________
   *Total Net Value .... $ ____________________

(*If the total is more that $50,000.00, Applicant will be asked to sign a statement promising to repay Foundation for costs of care at any such future date as the above assets are liquidated or transferred.)

C. Savings Accounts:
   Institution Where Located: Amount:

   ____
   ____

D. List Other Securities such as Stocks, Bonds, Cash Value of Life Insurance, etc.

   Description: Value:

   ____
   ____

9. Do y ou have Medi-Cal or Medicaid? ____________________ Medicare? ____________________

Medicare Supplement ______________________________ Other Insurance? ______________

Name of Company Types of Insurance Policy Number

____
____

10. Have you ever applied for Medi-Cal or Medicaid? ________ If yes, please describe: __________

____
____

I hear by authorize the Lions Eye Foundation of California – Nevada, Inc. to make any investigation concerning me and my dependents which is necessary to establish eligibility for assistance. This authorization constitutes a full and complete release from any liability resulting from disclosure of the required information. I declare under penalty of perjury under the laws of the State of California that the foregoing statement of fact provided by me is true and correct to the best of my knowledge and belief.

Signature of Patient
Or Responsible Party: ______________________________ Date ____________________

Signature of Sight Conservation Chairman or other Authorized Club Representative:

______________________________ Name of Club ____________________ Date __________
Sight Conservation Chairman

Lions Eye Foundation of California – Nevada, Inc.

2340 CLAY STREET, SAN FRANCISCO, CALFORNIA 94115
TELEPHONE (415) 600-3950
MAILING ADDRESS: P.O. BOX 7999, SAN FRANCISCO, CA 94120

NOTE: DO NOT USE THIS FORMA IF YOU ARE REFERRING A PATIENT WHO IS FINACIALLY ABLE TO PAY FOR HIS CARE

PATIENT REFERAL FORM

To: LIONS EYE FOUDATION OF CALIFORNIA – NEVADA, INC. Date: ____________________

From: Dr. ____________________

Address: ____________________ Phone: ____________________
Street City State Zip

Patient's Name: ____________________ Birth date ________ Sex ______

Address: ____________________ Phone: ____________________
Street City State Zip

Name of responsible
Adult (parent, guardian, etc.) ____________________

Address: ____________________ Phone: ____________________
Street City State Zip

This patient is being referred for the following reason: ____________________

The diagnosis is: ____________________

Findings of complete eye exam, including visual acuity, external, slit lamp, muscles and fundus, would be most helpful.

Signed: ____________________ M.D./O.D.

Sponsoring Lions Club ____________________

I verify that I have screened this patient with regard to the financial need and have found the patient is eligible for Foundation assistance. (Please **print** and sign your name to indicate you have screened the patient financially and have found him/her eligible for Foundation assistance.)

Authorized by ____________________ Title ____________ Phone ____________
Address ____________________
Insurance Information: ____________________
Policy Name, Numbers, etc

DO NOT WRITE BELOW THIS LINE

AUTHORIZED BY SCREENING COMMITTEE: YES ____ NO ____
Remarks: ____________________
Signed: ____________________
Chairman, Screening Committee, L.E.F.

HOSPITAL ADMISSION DATE: ____________________

Instructions to Clubs: Send the original and two copies of this form to the Lions Eye Foundation, P.O. Box 7999, San Francisco, CA 94120, for approval. When approved, the patient will be contacted and given an appointment and appropriate instructions.