AZ LIONS VISION & HEARING FOUNDATION
3124 E. Roosevelt St. Bldg. D #1
Phoenix, AZ 85008
602-267-7573

INSTRUCTIONS FOR OPHTHALMOLOGY ASSISTANCE

Enclosed you will find the application for the request of Ophthalmology assistance. Please complete all of the forms and return it to us plus all other information that is requested on the application.

- A letter from your physician if you have diabetes that states you have medical clearance for surgery.
- A letter from the surgeon stating the type of surgery needed.
- You must include Proof of Income (SSI. SS, Food Stamps, ADC, Interest, Dividends, Royalties, 401K, retirement funds, etc.) If you are required to file income taxes, please submit a copy of last year's tax forms.
- You must also provide picture identification (driver's license, passport or other form)
- You must provide proof of any health insurance you may have.

*****Please make copies of everything for your records. You may drop this information off in person to our office or mail at the address above.

A co-pay of $300 for Cataract Surgery or a co-pay of $400 for Retinal Surgery, maximum copay up to $450 will be required for all ophthalmology surgeries, this co-pay is for surgery for one eye only per year.

Once we receive all the information requested, your application will be reviewed by our Sight Committee in the order it is received. The obvious lifestyle of the applicant is taken into consideration and may include an interview with our Office Staff, Administrator, or Lions Club member.

Thank you,

AZ Lions Vision & Hearing Foundation

AZ Lions Vision & Hearing Foundation

3124 E. Roosevelt St. Bldg. D #1 Phoenix, AZ 85008
Phone: 602-267-7573 Fax: 602-267-7595

Ophthalmology Request for assistance

MUST BE ARIZONA RESIDENT FOR 6 MONTHS OR LONGER TO QUALIFY

*Office use only: Date received*_____ *Case number* _____

Applicant:_____Sex; Male / Female
(*Name; please print clearly)*

Address;_____Email Address:_____

City; _____Zip code; _____Phone; (___)_____

Date of Birth; _____Age;_____.

Contact Person; _____*Phone; (___)*_____.

*Address;*_____

City; _____*Zip code;* _____*Cell Phone; (___)*_____

Number of persons in Household; Adults _____Children _____How did you hear about us?_____

What is your Ethnicity? ☐ White/Caucasian _____ ☐ Hispanic _____☐ African American/Black_____

☐ Native American _____☐ Pacific Islander_____☐ Other

Disclaimer: No person shall be discriminated against because of race, religion, gender, sexual orientation, creed, age, color, marital status, physical handicap or disability, national origin, or veteran status.

Number of persons in Household: Adults ____ Children ___ How did you hear about us?_____
Copay: $300 Cataract surgery, $400 Retinal surgery with a maximum copay up to $450.00

Monthly Budget (the monthly expenses of your household)

Income: Husband $_____Wife $_____Other $_____

***Please list ALL other income to include everyone in the household**

Example - SSI, SS, Food stamps, ADC, Interest, Dividends, retirement Funds, child support, etc.

TOTAL MONTHLY INCOME (please total all of the above) $_____

Please List ALL monthly expenses;

Rent / Mortgage Payment	$_____
Utilities (phone, gas, water, electric)	$_____
Food	$_____
Insurance (Auto, Health Life etc)	$_____
Installments Payments	
Auto (include final date)	$_____
Loans / credit cards	$_____

TOTAL MONTHLY EXPENSES **$**_____

If you have NO income, please attach a separate sheet explaining your living arrangements.

See over – Please answer all questions and SIGN the application.

Insurance; AHCCCS, Medicare _____

Do you have Diabetes? _____ You must have a letter from your physician regarding the status of your diabetes before any surgical procedure is approved.

Have you visited a doctor concerning your eyes? YES ____ NO ____

If 'yes', Name of Doctor: _____ Phone:_____

TYPE OF SURGERY NEEDED_____

(Include copies of any information you have concerning your condition)

Important: You must enclose the first two (2) pages of Last Year's Federal Income Tax return if you filed. If you did not file, attach copies of proof of income (W2, check pay stubs etc).

The AZ Lions Vision & Hearing Foundation has not granted any authority, express or implied, to any person, organization, or government agency, including, but not limited to, any person, referral organization, Lions Club or Physician from whom you may have obtained this request for assistance, to act on behalf of, to act on behalf of or to otherwise bind the AZ Lions Vision & Hearing Foundation in any manner whatsoever. Neither this application form, nor your receipt of this application from any such source is a representation from the AZ Lions Vision & Hearing Foundation of any authority, actual or apparent, in such source all such expressions authority are hereby disclaimed. You should direct any questions regarding the services available through the AZ Lions Vision & Hearing Foundation, eligibility for such services, the cost of such services and this *request for assistance* directly to the AZ Lions Vision & Hearing Foundation at the address and/or phone number set forth on this form. There is no application fee associated with the Lions Vision and Hearing Foundation.

Release;

I for myself, my heirs, personal representatives, executors, administrators, and assigns, and on behalf of the patient if the patient is other than myself and I am the responsible party for the patient, waive, release and forever discharge the AZ Lions Vision & Hearing Foundation and the Lions Clubs of Arizona, their officers, directors, agents, representatives, successors and all co-operating entities and individuals from all claims, losses, damages which now exist or may hereafter arise in connection with my and/or the patients participation with any services rendered through AZ Lions Vision & Hearing Foundation.

To the best of my knowledge, I represent the information on this form to be correct. I acknowledge and understand this release thoroughly and authorize any service provider contracted by the AZ Lions Vision & Hearing Foundation to release to the Lions Vision & Hearing Foundation any information required.

I do hereby give the AZ LIONS VISION & HEARING FOUNDATION permission to use my picture in any publicity brochure that is deemed appropriate by the Foundation.

Signature_____ Date;_____

For patients / applicants under 18 years of age;

Any patient under 18 years old **MUST** have an authorization before being accepted. Responsible person has read and understands *request for assistance*. I am willing to accept the services provided by the AZ Lions Vision & Hearing Foundation for this minor child.

I do hereby give the AZ LIONS VISION & HEARING FOUNDATION permission to use my daughter/son picture in any publicity brochure that is deemed appropriate by the Foundation.

After you have read all of this form please sign and date below:

Signature;_____ Date; _____

Relationship to applicant; _____

FALSE STATEMENTS ARE GROUNDS FOR REFUSAL OF BENEFITS

(Office use only);

If referred by a Lions Club _____*Date*_____

(Name of club)

Recommended by _____*Phone*

_____

(Name of referring Lion)

Address _____*City* _____*Zip*_____

Revised 12/03/2020

Poverty Income Guidelines

# IN HOUSEHOLD	ANNUAL INCOME	MONTHLY INCOME
1	19,140	1,595
2	25,860	2,155
3	32,580	2,715
4	39,300	3,275
5	46,020	3,835
6	52,740	4,395
7	59,460	4,955
8	66,180	5,515

Revised 12/03/20

HIPAA Authorization Release Form

Authorization for Use or Disclosure of Protected Health Information
(Required by the Health Insurance Portability and Accountability Act, 45 C.F.R.Parts 160 and 164)

1. Authorization

I authorize LIONS SIGHT & HEARING FOUNDATION (healthcare provider) to use and disclose the protected health information described below to _____ (individual seeking the information).

2. Extent of Authorization

a. □ I authorize the release of my complete health record (including records relating to mental healthcare, communicable diseases, HIV or AIDS, and treatment of alcohol or drug abuse).

b. □ I authorize the release of my complete health record with the exception of the following information:
□ Mental health records
□ Communicable diseases (including HIV and AIDS)
□ Alcohol/drug abuse treatment
□ Other (please specify): _____

3. This medical information may be used by the person I authorize to receive this information for medical treatment or consultation, billing or claims payment, or other purposes as I may direct.

4. This authorization shall be in force and effect until _____ (date or event), at which time this authorization expires.

5. I understand that I have the right to revoke this authorization, in writing, at any time. I understand that a revocation is not effective to the extent that any person or entity has already acted in reliance on my authorization or if my authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest a claim.

6. I understand that my treatment, payment, enrollment, or eligibility for benefits will not be conditioned on whether I sign this authorization.

7. I understand that information used or disclosed pursuant to this authorization may be disclosed by the recipient and may no longer be protected by federal or state law.

Date:_____ _____
Signature

_____
Printed Name