



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

Wages \_\_\_\_\_
Pension \_\_\_\_\_
Unemployment \_\_\_\_\_
Social Security/SSI \_\_\_\_\_
Food Stamps \_\_\_\_\_
Housing Allowance \_\_\_\_\_
Other \_\_\_\_\_
TOTAL INCOME \_\_\_\_\_

TOTAL MONTHLY EXPENSES

Rent/Mortgage \_\_\_\_\_
Gas & Electric \_\_\_\_\_
Telephone \_\_\_\_\_
Medical \_\_\_\_\_
Clothing \_\_\_\_\_
Food \_\_\_\_\_
Other \_\_\_\_\_
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 # \_\_\_\_\_