EAST TENNESSEE LIONS DISTRICT 12N

SPECIAL SERVICES PROGRAM

P.O. BOX 444 POWELL, TN 37849

Application Information and Instructions

These instructions have been designed to assist in the completion of the Assistance Application. Please read the instructions carefully. If a question does not apply, write in "N/A".

Incomplete applications will not be considered.

Lions Club sponsors should work with the applicant to help complete the information. If any space provided is not adequate, additional pages may be used to answer questions more completely.

OBJECTIVE:

To provide financial assistance to residents of Lions District 12N who need extraordinary vision-related assistance and are unable to qualify for government assistance or fund such services themselves.

ASSISTANCE AVAILABLE:

The eligible amount will be determined at the time of the request. The eligible amount will not include amounts covered by TennCare, Medicare, Medicaid, health insurance nor grants available from other sources.

OTHER CONSIDERATIONS:

Physicians and other medical providers often reduce their fees for those in need of financial assistance. The Special Services Committee reserves the right to ensure the appropriate fees are obtained and reflected when determining Eligible Expenses.

The applicant may also be eligible for aid from other sources. All available assistance should be reviewed and eligible expenses adjusted if appropriate.

THE ASSISTANCE PROCESS:

1. The person needing assistance contacts a member of their local Lions Club.
2. If the local Lions Club believes the person may qualify, the application can be downloaded from the Lions Clubs of East Tennessee website: http://tnlions.org.
3. The Applicant and Sponsoring Lions Club will complete the application and mail it to Lions District 12N Special Services Program.

   Note: Incomplete applications will not be considered
4. The Special Services Committee in coordination with the sponsoring Lions Club will review the application and contact the appropriate persons when a decision has been made.

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ASSISTANCE APPLICATION

1. Applicant (patient) Name:_____

Address: _____

City/State/Zip: _____

Home Phone: _____ Cell phone: _____

Date of Birth: ___ - ___ - ____ Age: _____ Email address: _____

2. Parent/Guardian (for Child applicant): _____

Address (If Different): _____County: _____

City/State/Zip: _____

Home phone: _____ Cell / Work phone: _____

3. Reason(s) for request: (include diagnosis and treatment needed)

_____

_____

_____

_____

_____

Lions District 12N Special Services Committee may seek further medical, financial or other information as required, and it is understood by all parties that all approved funds shall be used for the intent and purpose stated in this application. Funds will only be disbursed to service providers. All information on and attached to this application is true and correct to the best of my knowledge. I understand any misrepresentation or falsehood will result in immediate and permanent disqualification from consideration.

_____ _____

Signature of Applicant (or parent if applicant is a child) Date

_____ _____

Lions Club Representative Date

_____ _____

Special Services Committee Representative Date

5. Please explain any current financial or health conditions that contribute to your need for assistance:

_____

_____

_____

6. Can any member of your family or friends contribute towards service costs? _____

7. Are you (applicant) covered by health insurance, Tenncare, Medicaid or Medicare? _____

Company/HMO name: _____

List Coverage Limitations: _____

8. Optometrist/Ophthalmologist: _____

Address: _____ Date Last Seen ____-____-_____

City / State / Zip: _____

Telephone Number: _____ Fax Number _____

Other Providers(s) involved and Phone Number(s):_____

_____

_____

_____

9. List members in your household excluding applicant:

Name	Relationship	Age

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FINANCIAL INFORMATION

(If something does not apply, enter N/A)

10. ANNUAL HOUSEHOLD INCOME:

Wages, Salary, and Tips	$ _____
Unemployment Compensation	$ _____
Social Security Benefits	$ _____
Welfare Benefits	$ _____
Veterans Benefits	$ _____
Alimony and Child Support Received	$ _____
Interest and Dividend Income	$ _____
Business Income (or Loss)	$ _____
Capital Gain (or Loss)	$ _____
IRA	$ _____
Pensions and Annuities	$ _____
Rental Income	$ _____
Farm Income (or Loss)	$ _____
Other Income	$ _____
Total Income	$ _____

11. ESTIMATED ANNUAL HOUSEHOLD EXPENSES:

Rent (House, Apartment, etc)	$ _____
House Payment	$ _____
Property / Liability Insurance	$ _____
Automobile Payment	$ _____
Monthly Electric Bill	$ _____
Gas (Natural or LP) Bill	$ _____
Telephone (Land Line & Cell)	$ _____
Medical Insurance	$ _____

Medical and Dental Expenses	$ _____
Food & Consumable Items	$ _____
Clothing	$ _____
Child Care	$ _____
Education	$ _____
Child Support	$ _____
Other Expenses	$ _____
Total Annual Household Expenses	$ _____

12. OUTSTANDING LOANS / DEBTS:

Institution	Purpose	Monthly Payment

13. SAVINGS AND INVESTMENTS:

Institution	Source	Amount

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Medical Information Release Form

Patient: _____ Date of Birth: _____Patient Phone#: _____

I, _____, the patient / guardian / Healthcare Power of Attorney (*circle one*), authorize

Lions District 12N Special Services Committee to release and/or discuss my medical information with the following Health Care Provider(s):

Physician / Provider Name: _____

Phone: _____ Fax: _____

Email: _____ Street Address: _____

City: _____ State:_____ Zip: _____

Additional Physician / Provider Name: _____

Phone: _____ Fax: _____

Email: _____ Street Address: _____

City: _____ State:_____ Zip Code: _____

Treatment dates to be disclosed: ❑ Entire ❑ Year to date ❑ Other _____

Purpose of the disclosure: ❑ Insurance ❑ Legal ❑ Continuing Care ❑ Personal ❑ Other _____

Specific description of the information to be disclosed: ❑ All

❑ History ❑ Correspondence ❑ Progress Notes ❑ Labs & X-rays ❑ Insurance ❑ Hospital

Specific information NOT to be released: _____

I understand that the purpose of this authorization is for the use and/or disclosure of my protected health information (PHI) and that it may contain information that is protected under state laws and federal regulations. I understand that once the above information is disclosed it may be subject to re-disclosure and will no longer be protected by Privacy Protection Rules.

I understand that I have the right to revoke this authorization at any time and that my revocation must be submitted to Lions District 12N Special Services Program. I understand my revocation is not affected to the extent that the Lions of District 12N representatives have relied upon it and have used the authorization to conduct a review of my application.

The health provider and their staff, officers and review committee are hereby released from all legal liabilities for the release of the above requested information to the extent authorized herein. Unless withdrawn, this consent will expire one year from the date signed.

Patient's Signature: _____ Date: _____

Parent or Guardian Signature: _____ Date: _____

Witness Signature: _____ Date: _____