PATIENT FINANCIAL STATEMENT AND APPLICATION

FOR EYE CARE AND TREATMENT THROUGH THE SPONSORSHIP OF

LIONS CLUBS INTERNATIONAL

P.O. Box 64

Jackson, Ca 95642

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 Name Age Relationship

1. _____ 3. _____
2. _____ 4. _____

Financial Information of Patient or Responsible Party:

1. **Current Employment:**

Name of employer: _____ Telephone: ( ) _____

Address: _____ Your Driver Lic. # _____

How Long Employed: _____ Social Security # _____

2. **Spouse Employment:**

Name of employer: _____ Telephone: ( ) _____

Address: _____ Your Driver Lic. # _____

How Long Employed: _____ Social Security # _____

3. If Unemployed, how long since you have worked: _____

4. If Retired, date of retirement: _____

5. **Monthly Income:**

Source: ___Salaries and Wages_____ Net Amount: _____

Source: _____ Net Amount: _____

Total Net Income: **$** _____

6. **List of Amounts Owed:**

To Whom: Amount

_____ _____

_____ _____

_____ _____

Total Amount Owed: **$** _____

7. Patient has been at current address how long? _____. If less than 1 year, please list prior address: _____

_____

8. **List of Assets:**

A. Market Value of Home: $_____

Less Amount of Mortgage owed: $_____

Net Value: $_____

B. Other Real Estate Owned: $_____

Less Amount of Mortgage owed: $_____

Net Value: $_____

*Total Net Value $_____

(*If the total is more than $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 **Amount**

_____

_____

9. Do you have:

a. Medi-cal or Medicaid? ____no _____yes, ID number: _____

b. Medicare? _____no _____yes, ID number: _____

c. Other Insurance? _____no _____yes, name of plan: _____

ID number: _____

d. Have you ever applied for Medi-cal or Medicaid? _____no _____yes

If yes, describe: _____

I hereby 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 that the foregoing statement of facts 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 Lions Club _____ Date: _____

THIS FORM MUST ACCOMPANY PATIENT REFERRAL FORM