PLANT CITY LIONS CLUB
SIGHT ASSISTANCE APPLICATION

Name: _____ Application #: _____

SSN: _____ Telephone: _____ Email: _____

Current Address: _____ City: _____ State: _____ Zip Code: _____

If at address less than 6 months, prior residence: _____ Are you able to work? _____

Employer: _____ How long: _____

Name of Insurance: _____ Do you have Medicaid? _____ Do you have Medicare? _____

If Unemployed, How Long: _____ When can you go back to work? _____ Type of Work you do: _____

Number in household: _____ Age & relationship of each member: _____

FINANCIAL INFORMATION:

Monthly INCOME of Household		**Monthly EXPENSES of Household**	
Your Income:		Mortgage / Rent:	
Father:		Telephone:	
Mother:		Cable or Satellite:	
Husband:		Water:	
Wife:		Electric:	
Others In Household:		Heating oil	
Aid Dependent Children:		Food	
Alimony:		Vehicle Insurance:	
Child Support:		Gas:	
Disability Comp.		Medical Insurance:	
Food Stamps:		Doctors:	
Medicaid (include number):		Dentists:	
Medicare (A or A/B):		Prescriptions:	
Rental Income:		Clothing:	
Retirement Pension:		Child Support:	
Social Security:		Alimony:	
Unemployment Comp.		Other Expenses:	
Veteran's Pension:		Other Expenses:	
Your Savings Balance:		Other Expenses:	
Other Income:		Other Expenses:	
Total Monthly Income:		**Total Monthly Expenses:**	

Federal and state compliance provisions require us to ask the following information:		
Sex:	Male or Female	
Race:	Caucasian	
	African American	
	Hispanic/Latino	
	Asian	
	Indian	
	Other (Specify)	
Date of Birth:		
Age:		
United States Citizen?		Yes No
Are you a Legal Resident?		Yes No
United States Veteran?		Yes No
Difference + or -	$	

Describe your sight problem: _____

_____

Date of Last Eye Examination: _____ Services Requested _____

Who referred you to the LIONS? _____

I am applying to the Lions Club for financial assistance for a vision examination, eyeglasses or surgery, if needed. I understand the information I give will be used to verify financial eligibility and also for referral to physicians or other vision care providers as necessary. I certify that all the above information is true and complete to the best of my knowledge.

_____ _____ _____

Signature of Applicant | Date Signed | Signature of Lions Club Witness

DO NOT WRITE BELOW THIS LINE

For Official Use Only:

The Sight Committee **APPROVED** the following:

Refer to Ophthalmologist for Examination: _____ Eyeglasses Only (patient has Rx): _____ Eyeglasses & Exam _____

Surgery or Medical Procedure: _____ Eye Prosthesis: _____ Other: _____

A majority of the Sight Committee **DID NOT APPROVE** this application. _____ Review Date: _____ Initial _____

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Authorization for Release of Information

Name: _____ DOB _____
Address: _____
City, State, Zip: _____
Phone Number: _____

I authorize the Plant City Lions Club **to release** information to:
Name of Provider or Facility: _____
Street Address: _____
City, State, Zip Code: _____
Phone #/Fax # (Include area code): _____

I authorize the Plant City Lions Club **to obtain** information from:
Name of Provider or Facility: _____
Street Address: _____
City, State, Zip Code: _____
Phone #/Fax # (Include area code): _____

Purpose: This information will only be used for my plan of services and will not be released to anyone else without my written request. Place checks in front of records authorize:
XXX Medical **XXX** Eye Medical ___Other (specify)_____

Specific Information Authorized: (select one or more as appropriate, check in front)
XXX Assessments **XXX** Progress Notes **XXX** Diagnostic Impression
__School Records __Treatment Plans __Treatment Summary **XXX** Laboratory Test Results:
__Other (specify): _____

One-time Use/Disclosure: I authorize the one-time use or disclosure of the information described above to the person/provider/organization/facility/program(s) identified. My authorization will expire:
___When the requested information has been sent/received.
XXX 90 days from this date. 7/14/2017
___Other (specify): _____

Periodic Use/Disclosure: I authorize the periodic use/disclosure of the information described above to the person/provider/organization/facility/program(s) identified as often as necessary to fulfill the purpose identified in this document. **My authorization will expire**:
XXX When I am no longer receiving services from the Plant City Lions Club.
___One year from this date. _____
___Other: _____

I understand that: I may cancel this authorization at any time by submitting a written request to the PCLC, except where a disclosure has already been made in reliance on my prior authorization. This document may be produced in alternative formats such as Braille, large print and audiotape

Signature of Client or Representative: _____ Date: _____
Relationship to Client (if requester is not the student): ___Parent ___Legal Guardian ____Other (specify): _____