PLANT CITY LIONS CLUB
SIGHT ASSISTANCE APPLICATION

7/26/2021

Enclosed is your application for eye glass assistance. Please fill out the entire form front and back, and return with any paper work you might have received from Medicaid, Medicare, or your insurance company regarding the cost of the glasses or rejection of coverage.

Please return to
Plant City Lions Club
Att: Sight Chairman
PO Box 1059
Plant City FL 33564-1059

Sincerely

Frank Cummings
Sight Chairman

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

MAIL FORM: Sight Committee, Plant City Lions Club, PO Box 1059, Plant City FL 33564

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 _____. ___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 (specify): _____

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): _____

MAIL FORM TO:
Sight Committee, Plant City Lions Club
PO Box 1059, Plant City FL 33564