

NEW MEXICO LIONS EYE BANK.
APPLICATION FOR SIGHT SAVING

PLEASE ANSWER ALL QUESTIONS

APPLICANT MUST BE INTERVIEWED BY A MEMBER OF A LOCAL LIONS CLUB

The New Mexico Lions Eye Bank., will not assume any financial obligation or responsibility until this application has been approved by the Board of Directors, and you have received their Official Authorization - Form No. 5, bearing an authorized signature of the New Mexico Lions Eye Bank Surgery.

PLEASE PRINT OR TYPE

1. Name of applicant in full _____
 First Middle Last SoSec# _____
2. Residence of applicant _____
 Street or Box City State Zip
3. Sex _____ Age _____ Birth date _____ Married _____ Single _____
4. Name of Parent or Guardian if applicant is a minor _____
5. Has previous application been made for treatment or hospitalization to the New Mexico Lions Eye Bank? Y / N

AGREEMENT OF APPLICANT (PARENT OR GUARDIAN, IF A MINOR)

Application is hereby made for surgery and hospitalization for the above. I agree for myself as applicant (parent or guardian if a minor) to abide by all the rules and regulations which are now in force and which may hereafter be adopted by the Board of Directors of the New Mexico Lions Eye Bank Accordingly, I hereby certify that a reasonable effort has been made to secure financial assistance from other possible sources of aid, including tax-supported agencies.

I am not able to pay for surgery or hospitalization of my self (or applicant, if minor) and understand same will be financed by the New Mexico Lions Eye Bank. I hereby absolve the New Mexico Lions Eye Bank of any responsibility in connection with the surgery or hospitalization of myself (or applicant, if minor). I understand their obligation is limited to the financing of such surgery or hospitalization as agreed to by me (parent or guardian if a minor) and authorized by the New Mexico Lions Eye Bank I also agree that any money I receive from Blue Cross/Blue Shield, Welfare, Medicare or any other insurance, is to be applied toward payment of any bills incurred by me, (or applicant, if minor) pertaining to eye surgery and hospitalization for this surgery, only.

In the event applicant is a ward, this agreement is to be signed by a guardian. A copy of the Court Order authorizing such appointment must be submitted with this application.

I certify that the above information and data, also the information and data given on the second page of this Application Form No. 2, is to the best of my knowledge and belief a correct and true statement.

I also certify that I have been a resident of the U. S. A. for a period of not less than one year.

6. Date _____, 20_____
7. Witnessed By _____
 (Must be a Lions Club Member)
8. Signed _____
 Applicant (Parent or Guardian if a Minor)
9. Address of Witness _____
 Street

 City State Zip
10. Lions Club Name _____ located _____

PLEASE PRINT OR TYPE

Please Answer EVERY QUESTION: (If it does not apply mark "no" or "none") otherwise forms will be returned, thus causing delay. If applicant is a minor or is living with and or supported by parents, data required pertains to both the parent or guardian and applicant.

Name of applicant _____ Age _____ DOB _____

If minor, name of parent or guardian _____

Name of Employer _____ 16. Date employed from _____ to _____

Own business? _____ Net Worth _____ Kind _____ Wages _____ Draws _____

If no income, how are you supported? _____

*Have you been accepted for assistance for eye surgery and or hospitalization from Welfare, Aid to Blind, Medical Aid to Aged, etc.? _____ If yes, give name of company or agency _____

*If no, explain circumstances and submit copy of agency's statement of rejection. _____

*Please note that if questions #19 and 20 are not answered and written documentation is not provided, this application will be returned.

Can any member of family contribute toward Surgery or Hospitalization? _____ To what extent? _____

Do you carry Blue Cross, Blue Shield, or any other medical or hospital insurance?

Please list name of company _____

24. Are you registered with the Medicare/Medicaid Program to cover doctor's fees? Y / N

ANNUAL INCOME

ASSETS

REAL ESTATE:

Salary of Applicant - NET..... \$ _____

Amount of ALL Mortgages.....\$ _____

Salary of Spouse - NET..... \$ _____

Bank Account-Savings-CDs.....\$ _____

Salary of Parent or Guardian - NETS \$ _____

Bank Accounts-Checking.....\$ _____

Social Security..... \$ _____

Stocks, MARKET VALUE.....\$ _____

Disability Pension.....\$ _____

Bonds, MARKET VALUE.....\$ _____

Retirement Pension.....\$ _____

Other assets..... \$ _____

Welfare Assistance.....\$ _____

Income other family members \$ _____

Rent you receive from property \$ _____

Other income.....\$ _____

TOTAL NET INCOME(Annually)..... \$ _____

TOTAL NET ASSETS.....\$ _____

LIST ANY UNUSUAL OR EXTENUATING CIRCUMSTANCES

Number in family dependent on income above _____

Certification by Local Lions

51. How long and under what circumstances have you known applicant or family? _____

52. Remarks or recommendations _____

I certify as a Lions Club member, to the best of my knowledge and through personal interview with the applicant, the above information is correct and I recommend the application.

53. Signature _____ 54. Address _____

Printed Name _____

55. I am a member in good standing of the _____
(Lions Club)

Located in _____
City State

NEW MEXICO LIONS EYE BANK.
CERTIFICATE OF SURGICAL PROVIDERS

**DO NOT PERFORM SURGERY UNTIL AUTHORIZATION FORM 5 IS RECEIVED
OR
AUTHORIZATION IS GIVEN BY TELEPHONE DIRECTLY FROM THE EXECUTIVE
DIRECTOR OR EXECUTIVE VICE PRESIDENT OF
THE NEW MEXICO LIONS EYE BANK.**

OTHERWISE WE WILL NOT BE RESPONSIBLE FOR ANY EXPENDITURES

PART A - ATTENDING OPHTHALMOLOGIST IS TO COMPLETE
PART B - SURGERY FACILITY IS TO COMPLETE
PART C - ANESTHESIA PROVIDER IS TO COMPLETE.

PLEASE ANSWER EVERY QUESTION, OTHERWISE FORMS
WILL BE RETURNED, THUS CAUSING A DELAY.

PART A:

DATE: _____

Patient's Name: _____ Sex: _____ Age: _____

Address: _____ City: _____ State: _____ Zip: _____

1. DIAGNOSIS: _____

2. TYPE OF SURGERY RECOMMENDED: _____

3. APPROXIMATE DATE RECOMMENDED FOR SURGERY: _____

4. PREVIOUS TREATMENTS FOR THIS
CONDITION: _____

5. DOCTOR'S FEE, INCLUDING EXAMS, SURGERY, POST-OP CARE & REFRACTION \$ _____

Name _____

Address _____

FORM NO. 3

PAGE 2.

6. RIGHT EYE _____ LEFT EYE _____ NUMBER OF HOSPITAL DAYS _____
7. WILL PATIENT NEED: GLASSES _____ OR CONTACT LENSES _____ AFTER SURGERY?
8. IS PATIENT COVERED BY MEDICARE? PLAN A _____ OR PLAN B _____
9. ARE OTHER SOURCES OF AID AVAILABLE? _____ DESCRIBE: _____

I HEREBY AGREE TO ACCEPT AUTHORIZED AMOUNT AS PAYMENT IN FULL.

PHYSICIAN SIGNATURE: _____ M.D.

PART B:

10. FACILITY'S FEE, AS PER OUR SCHEDULE ON PAGE 3 OF THIS FORM. \$ _____
- NAME: _____ PHONE: _____
- ADDRESS: _____ CITY: _____ STATE: _____ ZIP: _____

THIS INSTITUTION DOES HEREBY AGREE TO ACCEPT AUTHORIZED AMOUNT AS PAYMENT IN FULL.

SIGNATURE: _____ TITLE: _____

PART C:

11. ANESTHETIST'S FEE, AS PER OUR SCHEDULE ON PAGE 3 OF THIS FORM. \$ _____
- NAME: _____ PHONE: _____
- ADDRESS: _____ CITY: _____ STATE: _____ ZIP: _____

I HEREBY AGREE TO ACCEPT AUTHORIZED AMOUNT AS PAYMENT IN FULL.

SIGNATURE: _____

APPLICANT IS NOT TO BE CHARGED FEE IN EXCESS OF AMOUNT AUTHORIZED.

NEW MEXICO LIONS EYE BANK
2501 Yale Blvd SE, Suite 100
Albuquerque, NM 87106
(505)266-3937 FAX: (505)266-5560

APPLICANT'S PERMISSION
FOR SURGERY, HOSPITALIZATION AND CERTIFICATION OF RESIDENCE

PRINT OR TYPE

DATE PRIOR TO SURGERY

Date: _____

I hereby authorize Doctor _____

Address _____ City _____ State _____ Zip _____

the surgeon who has been selected by me (parent or guardian of applicant if a minor) to perform surgery pertaining to diseases or injuries of the eyes only, which he/she may recommend, authorize and prescribe, including the administering of anesthesia, the designation of the hospital, hospitalization therein, and postoperative care and/or any subsequent surgery or hospitalization pertaining thereto, to be performed on

_____, myself (or minor)

(Name of Applicant)

I hereby absolve the New Mexico Lions Eye Bank., of any responsibility in connection with the surgery, hospitalization or postoperative care of myself (or minor).

If I am to receive assistance, I understand the cost thereof as may be authorized by the New Mexico Lions Eye Bank., will be financed by them, as indicated on Authorization Form No. 5 bearing authorized signature. I agree any funds I receive from insurance, etc. is to be applied toward payment of bills. No other illness will be covered by the Authorization.

I understand that no surgery is to be performed until I have signed this form and I have received Authorization Form No. 5, or in an EMERGENCY situation, authority has been given by fax or phone directly from the Eye Bank Board. I understand that the New Mexico Lions Eye Bank, will not be responsible for any expenses if these instructions are not followed.

I certify I have been a resident of the United States of America for a period of not less than 1 year.

Signature of Applicant (or parent or guardian if a minor)

WITNESS:

Name: _____

Address: _____

Phone #: _____