

**NEW MEXICO LIONS EYE FOUNDATION
APPLICATION FOR PAYMENT OF SIGHT SAVING SURGERY**

AUTHORIZATION OF AND PAYMENT ON CASES:

All applicants for financial assistance from the New Mexico Lions Eye Foundation should be sponsored by a local Lions Club in Multiple District 40 without regard to the applicant's status as a member of a Lions Club or being a relative of a Lions Club member. The sponsoring of a case is not a responsibility to be taken lightly; nor is the task of insurmountable proportions. It is the responsibility of the sponsor to personally interview the applicant or the applicant's family in order to acquaint themselves with the case and to complete and return all necessary forms, along with a recommendation, to the Eye Foundation Board so that they may issue authorization for financial assistance. These forms must be received to the Eye Foundation Board at a date prior to the date of surgery as the **BOARD CANNOT AUTHORIZE FUNDS FOR SURGERY ALREADY PERFORMED.**

Upon receipt of a completed application, the Board will review the case to determine the financial eligibility of the applicant. If the applicant is found to be within the eligibility requirements, the Board will proceed to issue written authorization which will be necessary before we are able to process any statements received pertaining to that case. If the case is denied, the Board will contact the sponsoring Lion and inform them of this fact.

PROCEDURE FOR AUTHORIZATION:

The following forms are provided to the public for the submission of information which is necessary for the Board to authorize a case:

1. *Instruction Sheet* - This sheet contains all necessary information to complete the application. It is important for the sponsoring Lion to read this information carefully and to follow the instructions closely.
2. *Application for Surgery and Hospitalization* - This form is to be completed by the sponsoring Lion at their interview with the applicant. It should be noted that all forms are to be legibly completed, and that all information required is given. After supplying this information, the local Lion certifies the information as being correct to the best of their knowledge by the form.
3. *Certificate of Surgical Providers* - This form is to be completed by those who will be providing services during the applicant's eye surgery. Again, all information required should be supplied and the form signed by the attending Ophthalmologist, a person of authority at the facility where surgery will be performed and the anesthesia provider. Fees stated on this form should be in accordance with usual and customary fees. This is our assurance that all providing services during the applicant's surgery are willing to cooperate with our effort to assist those less fortunate.

4. *Applicant's Permission for Surgery and Hospitalization and Certification of U.S. Residency* - This form is our legal protection and is to be completed by the applicant, and witnessed by a responsible person.

IMPORTANT - PLEASE NOTE: BEFORE FORWARDING THE FORMS TO THE BOARD, THE SPONSORING LIONS CLUB SHOULD REVIEW THE FORMS TO ASCERTAIN THAT ALL NECESSARY INFORMATION IS PROVIDED, THAT ALL NECESSARY SIGNATURES ARE ON THE FORMS. **THE NEW MEXICO LIONS EYE FOUNDATION CANNOT ASSUME ANY FINANCIAL RESPONSIBILITY FOR TREATMENT GIVEN WITHOUT AUTHORIZATION.**

5. *Official Authorization* - This form is issued to the surgery facility if the applicant is found to be eligible for the Board's assistance. This form indicates the amount authorized for the surgery to be performed. One copy of the original authorization form is to be retained by the NM Lions Eye Foundation with copies being distributed to the doctor, anesthesiologist and to the hospital upon admission. This Form 5 reiterates that the applicant is not to be billed for amounts in excess of our authorization. Any insurance proceeds should be deducted from the Board's allowance prior to billing the New Mexico Lions Eye Foundation.

It is very important that the sponsoring Lion read and familiarize themselves with these forms so that all necessary information is submitted and that all instructions are followed. The sponsoring Lions Club acts as a representative of the New Mexico Lions Eye Foundation, and is expected to be of assistance in the handling of the case as it becomes necessary. This may involve providing information or assistance to the applicant and occasionally contacting the doctor or hospital to gather additional information. It has been our experience that most physicians and hospitals will cooperate with the Eye Foundation, once they are made aware that we are a charitable organization.

Upon receipt of statements from doctors and hospitals for authorized cases, the Board will process these statements promptly and remit our payments to the extent of our authorized amount for that case.

PATIENT INSTRUCTION SHEET
Please Retain for Reference

NEW MEXICO LIONS EYE FOUNDATION

IMPORTANT-READ CAREFULLY and PLEASE FOLLOW INSTRUCTIONS

DO NOT PROCEED with surgery or hospitalization before receiving notification from the Eye Foundation.

QUALIFICATIONS

The applicant (if a minor, parent or guardian) must be unable to pay for surgery and hospitalization and must come within the scope of our financial eligibility requirements.

PROCEDURE

1. Every applicant must be sponsored by a local Lion. Form No. 2 is to be completed by a Lions Club member after interviewing the applicant, thus establishing financial eligibility and personal contact. Form No. 3 is to be completed by the attending ophthalmologist, stating type of surgery, date and fee. The facility where surgery will be performed, in addition to the anesthesia provider, are also to sign the form indicating their willingness to participate with our charitable program. Form No. 4 is our legal protection and certification of residence, which must be dated, signed and witnessed BEFORE surgery.
2. Please be sure nothing is left blank. Draw a line or write "none" where applicable. Forms containing unanswered questions, or the absence of a written denial letter from a tax supported agency, will result in the return of the application, thus causing a delay in approval.
3. Please advise regarding Medicare - one or both plans. The Eye Foundation will pay that part of surgery and hospitalization expenses not covered by Medicare. Medicare will pay 80% of the cost of post-surgical glasses. The Eye Foundation will pay the balance.
4. When all forms are completed, mail to the Eye Foundation. If everything is in order and the case is approved, the official authorization will be sent to the physician's office. This will authorize the amount of money allowed for surgery, hospitalization, anesthesia and/or glasses. A copy of Form No. 5 is to be presented to the surgeon, one to the hospital, and one to the anesthesiologist.
5. If the application is rejected, the applicant and the sponsoring Lions Club will be notified. All decisions are final. There is no appeal process.

RESTRICTIONS

1. Glasses - allowed ONLY as part of the authorized surgery.
2. The Eye Foundation will not accept applications or pay for any illness other than that pertaining to diseases or injury to the eye.
3. Applicant being unable to pay, is not to be charged for surgical or hospital expenses.
4. Patient must have resided in the United States for a period of not less than 1 year.

SELECTION OF DOCTOR

The applicant (parent or guardian if a minor) is to select the doctor. Preferred provider is: *Eye Associates of New Mexico*. Other providers are acceptable however.

**NO BILL WILL BE PAID UNTIL AUTHORIZATION FORM NO. 5 IS ISSUED,
BEARING AN AUTHORIZED SIGNATURE OF AN OFFICER OF THE NEW MEXICO
LIONS EYE FOUNDATION DATED PRIOR TO THE DATE OF SURGERY.**

NEW MEXICO LIONS EYE FOUNDATION.
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 Foundation, 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 Foundation.

PLEASE PRINT OR TYPE

Name of applicant in full _____ Phone # _____
First Middle Last

Residence of applicant _____
Street or Box City State Zip

Sex _____ Age _____ Birth date _____ Married _____ Single _____

Name of Parent or Guardian if applicant is a minor _____

Has previous application been made for treatment or hospitalization to the New Mexico Lions Eye Foundation? 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 Foundation. 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 myself (or applicant, if minor) and understand same will be financed by the New Mexico Lions EYE Foundation. I hereby absolve the New Mexico Lions Eye Foundation 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 Foundation. 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 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.

Date _____, 20____

Witnessed By _____
(Must be a Lions Club Member)

Signed _____
Applicant (Parent or Guardian if a Minor)

Address of Witness _____
Street

_____ City State Zip

Lions Club Name _____ Located _____

SEE SECOND PAGE

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 _____ 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 with *** 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 _____

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

Social Security..... \$ _____ Stocks/Bonds, VALUE..... \$ _____

Disability Pension..... \$ _____ Other Assets..... \$ _____

Retirement Pension..... \$ _____ **TOTAL NET EXPENSES..... \$ _____**

Welfare Assistance..... \$ _____

Income other family members \$ _____

Rent you *receive* from property \$ _____

Other income..... \$ _____

TOTAL NET INCOME(Annually).. \$ _____

EXPENSES:

Rent/Mortgage Payment.....\$ _____

Utilities.....\$ _____

Vehicle Payment.....\$ _____

Medical Expenses.....\$ _____

TOTAL NET EXPENSES.....\$ _____

Number in family dependent on income above _____

Certification by Local Lions

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

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.

Signature _____ Address _____

Printed Name _____

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

Located in _____
City State

******* EACH PATIENT MUST HAVE APPLIED TO AND BEEN DENIED FUNDING FROM A TAX SUPPORTED AGENCY; WRITTEN DENIAL SHOULD ACCOMPANY THIS APPLICATION*******

STATEMENT OF APPLICANT UNDERSTANDING

Applicant _____ Phone # (____) _____
First Middle Last

Address _____
Street City State Zip

I recognize that I am applying for financial assistance from the Lions Club. The Lions Club, Lions Club International and all of their associated organizations (“Lions”) are non-profit organizations. They are NOT medical providers and are NOT subject to federal privacy laws and regulations.

I understand that I have NO privacy rights to the information I give to Lions.

Signed _____ Date _____
Applicant

Witnessed by (print name) _____ Signed _____
(Must be a Lions Club Member)

NEW MEXICO LIONS EYE FOUNDATION.
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 FOUNDATION**

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: _____

DIAGNOSIS: _____

TYPE OF SURGERY RECOMMENDED: _____

APPROXIMATE DATE RECOMMENDED FOR SURGERY: _____

PREVIOUS TREATMENTS FOR THIS CONDITION: _____

DOCTOR'S FEE, INCLUDING EXAMS, SURGERY, POST-OP CARE \$ _____

Name _____

Address _____

RIGHT EYE _____ LEFT EYE _____ NUMBER OF HOSPITAL DAYS _____

WILL PATIENT NEED: GLASSES _____ OR CONTACT LENSES _____ AFTER SURGERY?

IS PATIENT COVERED BY MEDICARE? Y or N PLAN A _____ OR PLAN B _____

ARE OTHER SOURCES OF AID AVAILABLE? _____ DESCRIBE: _____

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

PHYSICIAN SIGNATURE: _____ M.D.

PART B:

FACILITY'S FEE \$ _____

NAME: _____

PHONE: _____

ADDRESS: _____ CITY: _____ STATE: _____ ZIP: _____

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

SIGNATURE: _____ TITLE: _____

PART C:

ANESTHETIST'S FEE \$ _____

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 FOUNDATION

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 Foundation, 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 Foundation will be financed by them, as indicated on Authorization Form 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 5, with authority has been given by fax or phone directly from the Eye Foundation Board. I understand that the New Mexico Lions Eye Foundation 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 #: _____

NEW MEXICO LIONS EYE FOUNDATION

OFFICIAL AUTHORIZATION

The Board of Directors of the New Mexico Lions Eye Foundation has authorized a reimbursement/payment for sight saving eye surgery for _____
(Name of Applicant)
of _____ recommended by the _____
(City, State) (Local Lions Club)
of _____ Such reimbursement or direct payment to the
(City, State)
Doctors and/or hospital is authorized in an amount not to exceed \$ _____

Once the surgery has been completed, a copy of the physicians/hospital charges will be forwarded to the New Mexico Lions Eye Foundation prior to the funds being disbursed. After a brief review of these charges by the Board, the authorized funds will be forwarded to the appropriate party.

NEW MEXICO LIONS EYE FOUNDATION

BY: _____
(President/Executive Vice President/Treasurer)

WITNESSED BY:

_____ Date ____ / ____ / ____
(Executive Director NMLEB)

**ESTIMATE SUMMARY OF PROFESSIONAL SERVICES OF
PHYSICIANS; SURGICAL FACILITY; ANESTHESIA PROVIDER;
MEDICALLY NECESSARY MATERIALS**

PHYSICIANS FEES _____

SURGICAL FACILITY _____

ANESTHESIA PROVIDER _____

MEDICALLY NECESSARY
MATERIALS _____

PATIENT'S CONTRIBUTION _____ ()

LIONS CLUB CONTRIBUTION _____ ()

TOTAL DIFFERENCE ON SERVICES _____

TOTAL REQUEST FOR FINANCIAL
ASSISTANCE _____

AMOUNT APPROVED BY EYE
FOUNDATION _____

DATE APPROVED _____

SIGNATURE: _____ PRES. _____ VP