



**NORTHWEST OHIO LIONS EYE CARE FOUNDATION. INC.**

*All Information provided in this application will be kept confidential.*

**WE SERVE** *Allen, Auglaize, Defiance, Fulton, Hancock, Hardin, Henry, Logan, Lucas, Mercer, Paulding, Putnam, Shelby, Van Wert, Williams and Wood Counties.*

Date of Application \_\_\_\_\_ Case Number \_\_\_\_\_

Name of Applicant \_\_\_\_\_ Date of Birth \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_

Zip Code \_\_\_\_\_ County \_\_\_\_\_ Telephone No. \_\_\_\_\_

Parent's Name (if child) \_\_\_\_\_ US Citizen?  Yes or  **No**

**If No**, legal residency is authorized by  Green Card or  Visa?

**Are you a Veteran?**  Yes or  No

**NATURE OF REQUEST/REFERRAL:**

(Medical, Surgical or Visual Aids) \_\_\_\_\_

Who Referred You to Foundation? \_\_\_\_\_ Phone#: \_\_\_\_\_

Previous Lions Club Assistance?  Yes  No If yes, which Club \_\_\_\_\_

Current eye problem:  Exam  Glasses  Surgery (limit 1 eye cataract)  Other

Describe your visual need(s)/goals \_\_\_\_\_

Eye Doctor's Name \_\_\_\_\_

Address \_\_\_\_\_ Telephone # \_\_\_\_\_

**EMPLOYMENT**

Are you currently employed?  Yes  No

If you are employed, where? \_\_\_\_\_ Income \$ \_\_\_\_\_

Is spouse employed?  Yes  No

If spouse is employed, where? \_\_\_\_\_ Income \$ \_\_\_\_\_

If you are employed is this Lions assistance needed to retain your job?  Yes  No

If you are unemployed, will this Lions assistance help in obtaining a job?  Yes  No

Type of employment? \_\_\_\_\_

**INSURANCE -- For surgical or medical requests**

Are you on Medicaid or Medicare?  Yes  No

Do you have Medical insurance?  Yes  No

If yes, name of insurance company \_\_\_\_\_

Have you applied for the Affordable Care Act? (Obamacare)  Yes  No

If you have applied for Affordable Care Act (Obamacare), date \_\_\_\_\_

Name of company applied to \_\_\_\_\_

(Applicant must comply with ACA requirements)

(Please also complete the second page of this form)

**FINANCIAL**

Can you participate in payment or partial cost of services requested?  Yes  No

Total number of persons in your immediate family living at the above address, including yourself \_\_\_\_\_

Number of children under age 18 \_\_\_\_ over age 18 \_\_\_\_

Source of family income before taxes:

- Salary  Social Security  Disability  Child Support  Pension

Amount received **yearly** from all financial sources \$ \_\_\_\_\_

**Please attach copies of verification of income documents.**

Do you  rent  own or  are you buying a home? Monthly payment \$ \_\_\_\_\_

Current Monthly household expenses:

Food \$ \_\_\_\_\_

Telephone \$ \_\_\_\_\_

Cell phone \$ \_\_\_\_\_

Cable/Internet \$ \_\_\_\_\_

Utilities \_\_\_\_\_ \$ \_\_\_\_\_

(Electric/Gas/ Water) \$ \_\_\_\_\_

Car payment \$ \_\_\_\_\_

Car expenses \_\_\_\_\_

(Maintenance/gas) \$ \_\_\_\_\_

Insurance \_\_\_\_\_

(Life/health/car/home)\$ \_\_\_\_\_

Other (please list) \_\_\_\_\_

\_\_\_\_\_ \$ \_\_\_\_\_

\_\_\_\_\_ \$ \_\_\_\_\_

\_\_\_\_\_ \$ \_\_\_\_\_

**When you have completed this form please send to: 419-371-5515**

**Darlene Roll NWOLECF President, 1385 TR 216, Bellefontaine, OH 43311**

***I certify that all information provided in this application is accurate and complete to the best of my knowledge.***

**SIGNED:** \_\_\_\_\_

**(Applicant or legal guardian of applicant)**

**NOTE:** Enclosed is a HIPAA Release of Medical Information to be completed by the applicant and a Doctor's form which must be completed by your Doctor. (Only the Doctor can complete this medical information we need regarding your vision status). The doctor should send this completed form directly to our President.

Thank you for completing the form and after receiving the doctor's information, we shall consider your request. We meet quarterly (during the months of February, May, August & November) to discuss all cases.