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?

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	$ _____	Car expenses (Maintenance/gas)	$ _____
Telephone	$ _____	Insurance	
Cell phone	$ _____	(Life/health/car/home)	$ _____
Cable/Internet	$ _____	Other (please list)	
Utilities		_____	$ _____
(Electric/Gas/ Water)	$ _____	_____	$ _____
Car payment	$ _____	_____	$ _____

When you have completed this form please send to: 419-371-5515
Darlene RollNWOLECF President, 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.