SIGHT SERVICES APPLICATION

Ellijay Lions Club Charities, Inc.

P.O. Box 746

Ellijay, GA. 30540

GUIDELINES / DIRECTIONS:

1. Services are provided for **legal Gilmer County residents** with at least one year of residency who experience extreme financial hardship and are unable to receive assistance from other sources.

2. The Ellijay Lions Club will not pay for expenses incurred prior to the APPROVAL of an application by the Director of Vision Services.

If you are approved, you will be contacted by first class mail. MAKE SURE YOUR ADDRESS IS CORRECT!!! If mail is returned to the Ellijay Lions Club, there will be no follow-up!!!

3. DO NOT SCHEDULE ANY EYE APPOINTMENT OR EYE SURGERIES WITHOUT PRIOR APPROVAL BY THE ELLIJAY LIONS CLUB

4. **IMPORTANT**: Complete the entire application. If a question does not apply to you, do not leave it blank! Write in N/A. Failure to answer all questions and supply necessary signatures on the back of the application will only cause you UN-NECESSARY DELAY.

1. Name of Person Needing Sight Service (Last. First. Middle) – 2. Social Security Number – 3. Date of Application

4. Name of Parent (if applicant is a child) 5. Date of Birth of Applicant 6. Age of Applicant

7. Mailing Address (P.O. Box or Street # Apartment # City State Zip Code

8. Street Address (if different from above) Apartment # City State Zip Code

9. Home Phone Number 10. Work Phone Number 11. Home Phone Number of Close Friend or Relative

12. County 13. Sex (Circle One) M F 14. Race (Circle One) White - African American - Hispanic - Asian -Other

15. Insurance: Medicare. Medicaid, Private Insurance (Circle Name(s) and Write in Policy Numbers of Every Insurance Policy in your Possession)

Medicare Number Medicaid Number Private Insurance Name

16. Does Applicant Work? Y N 17. If Applicant Does Not Work, State Reasons 18. Would Applicant Like to Work

19. List Names & describe illnesses of anyone in your household (including yourself) who is medically or mentally disabled

20. How long have you been a Gilmer resident? 21. Have you divested yourself of funds in the last 2 yrs.?

22. How many people in your household?

23. State reason why you cannot afford vision care at this time.

24. List all persons who live in your household:

Name	Relationship	Age

FINANCIAL INFORMATION:

Supplementary Security Income (SSI) $_____

Social Security Disability Income (SSDI) $_____

Social Security (SS) $_____

List monthly income earned on a job by you and by each person in your household who works

Employer	Monthly Gross	Monthly Net

Monthly amount of all other income received by you and all other household members: If more than one person receives the same type of income, add the amounts together and write in the total amount.

Food Stamps $_____

Welfare (AFDC) $_____

Veterans Benefits $_____

Pensions / Retirement Benefits Child Support $_____

Other Income $_____

ASSETS:

Savings Acct. $_____

Checking Acct. $_____

Stocks & Bonds(Market Value) $_____

Face Value of CD's $_____

Value of Home/Land/Property $_____

Boats $_____

Cars/Trucks $_____

MONTHLY EXPENSES:

Rent or House payment	$_____
Gas or Oil (home Heat)	$_____
Electricity	$_____
Water/Sewage/Trash pickup	$_____
Phone	$_____
F600	$_____
Medicine	$_____
Car/Truck Payments	$_____
Insurance: Life/Health/Car/Home	$_____
Charge Cards	$_____
Total Monthly Expenses	$_____

Applicant MUST read and sign this Statement

"I fully understand that the services provided by the Ellijay Lions Club of Ellijay, Georgia are limited to persons unable to pay for or receive from other sources this assistance. In consideration of these services, I release and discharge all persons rendering such services from any claims I may have arising from services so rendered. I am aware that the Ellijay Lions Club will not pay for any vision care expenses billed to me prior to the approval of this application. I also understand that my application may be reviewed by the Ellijay Lions Club and medical professionals.

_____

Signature of Applicant (or Parent if Applicant is a Child)

_____

Witness (If Applicant signs with an X)

MEDICAL INFORMATION:

Have you ever received vision care through the Ellijay Lions Club?

_____Yes _____No If so when? _____

Describe your eye condition:

Right eye _____

Left eye _____

Check the services you think you need:

_____Eye Examination _____Eye Glasses

Is your eye condition the result of an injury? Please explain:

_____

_____

_____

When did your vision problems begin? _____Month _____Year

Describe how your vision impairment affects your life:

_____

_____

_____

When was your last eye examination? _____Month _____Year

Have you ever or do you currently wear corrective lenses?

_____Yes _____No If yes, please answer the following:

_____ Single Vision _____Bifocals _____Trifocals _____Contacts

How long have you been wearing your current eyeglasses? _____Years

Who is your eye doctor?

Name: _____ Phone: _____

_____Optometrist (OD) Ophthalmologist (M.D.)

Address: _____ City _____ State _____ Zip Code_____

List/Describe other medical problems you have: _____

_____

MEDICAL RELEASE

THIS STATEMENT MUST BE COMPLETED BY THE APPLICANT/PARENT OR GUARDIAN.

"I hereby give permission for my medical records to be released to the Ellijay Lions Club and to any eye specialist, hospital, medical professional, or agency involved with my vision care."

_____

Signature of Applicant (or Parent if Applicant is a child)

_____

Witness (If Applicant signs with an X)

LIONS CLUB RECOMMENDATION

Approve _____ Disapprove _____ Date _____

If disapproved, state reason:

_____

_____

Notes:

You must accompany the application with photocopies of your Social Security Card, Medicare or Medicaid Card and any active Insurance Card, and your Drivers license.

If you have been a recipient of eyeglasses in the past from the Ellijay Lions Club, be advised that there is a four year waiting period from your last acquisition of eyeglasses before eligibly will resume. Previous history of activity on approvals or denials are on file to document your previous services provided by the Ellijay Lions Club.

Notes:

Failure to sign the Medical Release (above) will prevent any action regarding your application for services. Without this Signature, federal law prohibits our partner optometrists and eyeglass resources from providing your requested service.

All information submitted by you will be kept confidential in accordance with the Health Information Privacy Act.

Thank you!