Florida Lions Foundation for the Blind, Inc.

PROJECTS FORM

Case # _____ Date Entered: _____ DOB: _____

Last Name: _____ First Name: _____ Middle Initial: _____

Address: _____

(Client Info)

City: _____ State: _____ Zip Code: _____

Phone: _____ Diabetic: Yes_____ No_____ Age: _____ Sex: _____

SSN: _____-_____-_____ Monthly Income: $_____ # Dependents _____

District: _____ Sponsoring Club _____

Chairperson Name: _____

(Club/Chairperson Info)

Address1: _____

City1: _____ Zip Code1: _____ Phone1: _____

Doctor Name: _____

(Doctor Information)

NOTE:
COMPLETED BY PROJECT CHAIR ONLY

Address2: _____

City2: _____ State2:_____ Zip Code2: _____

Phone2: _____ Fax2: _____

Procedure: _____

_____

ESTIMATED AMOUNTS

Surgery: $_____ Anesth: $_____ Facility1: $_____ Misc: $_____ Total: $ _____

FOR FOUNDATION USE ONLY DO NOT FILL IN BELOW

APPROVED AMOUNTS

Surgeon $_____ Anesth $_____ Facility: $_____ Misc: $_____

Co-Pay: $_____ Savings: $_____ Foundation Funds: $_____

ACTUAL AMOUNTS PAID

Surgeon Paid: $_____ Surgeon Date: _____ Check1 #: _____

Anesth Paid: $_____ Anesth Date: _____ Check2 #: _____

Facility Paid: $_____ Facility Date: _____ Check3 #: _____

Misc Paid: $_____ Misc. Date: _____ Check4 #: _____

Total Requested: $_____ Total Paid: $_____ Total Saved: $_____

Case is active until Date Completed is filled in Date Completed: _____

Club Sight Chairperson Signature: _____ District Sight Chair Signature: _____