DIRECTIONS FOR PERSONAL HEALTHCARE ASSISTANCE APPLICATION

APPLICATION INFORMATION

The Idaho Lions Sight and Hearing Foundation Personal Healthcare Assistance program offers financial assistance to individuals in need of vision and hearing care. Assistance is based on financial need and availability of funds.

ALL SERVICES ARE ONCE PER LIFETIME

You may be eligible for financial assistance if you:

- Have no health insurance
- Are not eligible for government assistance (Medicare or Medicaid for example)
- Can show you have financial need
- Provide the Idaho Lions Sight and Hearing Foundation with necessary information about *all* sources of household income

Application process:

- Complete application in its entirety before submitting, expect a delay in the review process if your application information is incomplete
- If applicant is a minor or is living with/being supported by parent(s)/guardian, all information required pertains to both the applicant and the parent(s)/guardian
- Assistance is based on federal poverty guidelines
- Any services provided without prior authorization from the Idaho Lions Sight and Hearing Foundation is the applicants full financial responsibility
- You will be contacted by mail if you're approved

SUBMITTING YOUR APPLICATION

Mail your application to:

Idaho Lions Sight and Hearing Foundation
1090 N. Cole Rd., Boise, ID 83704

OR

Fax application to:

208.338.6543

DOCUMENTATION CHECKLIST

Applications for assistance must include all of the following documents that apply to you and your household. **We require income documentation for all members of the household. Please attach copies with the application.**

Medicaid Denial Letter

- *For sight restoring surgeries only*
- In order for the Foundation to assist you must have applied for and been denied by Medicaid.
  - Provide a copy of the denial letter from the *Department of Health and Welfare*
    Phone: (208)334-6700
    Toll Free: 1-877-456-1233

If you have income you MUST PROVIDE:

- **Award letters for all income sources**
  - Social Security benefits
  - Unemployment benefits
  - SSI Benefits
  - All welfare assistance (food stamps, etc.)
  - Retirement pension
  - Child support
  - Alimony
  - V.A. benefits
- **Pay stubs for the last 2 months**
- **Income tax return for previous year**

If you have NO income:

- Explain in detail how you're supported and by whom, either on designated section of the application or by submitting a letter with the application.

*If you have questions regarding the application process call the Foundation office at 208.338.5466, Monday – Friday, 8:30am – 4:30pm

DO NOT SUBMIT WITHOUT INCOME DOCUMENTATION

APPLICATION FOR PERSONAL HEALTHCARE ASSISTANCE

APPLICANT INFORMATION	
Name:	SS#:
Address:	Phone:
City:	Email:
State:	Birthday: Age: Sex:
Zip:	Marital Status:
Name of parent/guardian *(if applicant is a minor):*	

EMPLOYMENT INFORMATION	
Name of Employer:	Dates Employed:
If no income, how are you supported? *(If more room is needed please use the back of this application or attach a letter to explain. We may require a reference)*	

Have you applied for assistance from any other agency/insurance co.?	Yes	No	If yes, name of agency:
Can a family member or friend contribute to the cost?	Yes	No	To what extent:
Do you have insurance, Medicaid or other?	Yes	No	Name of carrier(s):

FINANCIAL INFORMATION			
How many people are in your household? *(Including yourself, spouse, and others claimed on your taxes)*		Are you a legal resident of the United States?	
INCOME RECEIVED - **ANNUALLY**		REAL ESTATE/ASSETS	
Income of Applicant	$	Checking Account Balance	$
Income of Spouse	$	Savings Account Balance	$
Income of Dependent(s)	$	Present Market Value of Home	$
Social Security Benefits	$	Equity in Real Estate	$
SSI Benefits	$	Insurance (cash value)	$
Welfare Assistance (Food stamps, cash assistance)	$	Stocks (market value)	$
Other Income: Pension, unemployment, etc.	$	Bonds	
TOTAL INCOME	$	TOTAL ASSETS	$
EXPENSES			
Rent/Mortgage	$	Other Expenses Please Explain:	$
Utilities	$		
TOTAL MONTHLY EXPENSES	$		

APPLICATION FOR PERSONAL HEALTHCARE ASSISTANCE

INITIAL & SIGN

INITIAL HERE	
	I certify that all the information provided on this application is true and complete to the best of my knowledge.
	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 understand that the information provided will be verified and consent to the use of any materials in connection with the treatment of myself (or applicant, if minor) and authorize the Idaho Lions Sight and Hearing Foundation to use same for public information.
	I agree for myself as the applicant (parent/guardian if minor) to abide by all rules and regulations which are now in force and which may hereafter be adopted by the Officers of said Idaho Lions Sight and Hearing Foundation.
	I understand that I will be liable for full payment of any services if any of the above information is given under false pretenses. I also agree that any money I receive from an insurance company or Medicare is to be applied toward payment of any bills incurred by me, (or applicant, if minor) pertaining to the services requested, only.
	I hereby absolve the Idaho Lions Sight and Hearing Foundation of any responsibility in connection with the services for myself (or applicant, if minor). I understand their obligation is limited to the financing of such services as agreed to by me (parent/guardian, if minor) and authorized by the Idaho Lions Sight and Hearing Foundation
	I agree that after surgery is complete or hearing aids received, I will write a letter of acknowledgement to the Idaho Lions Sight and Hearing Foundation letting them know what impact their assistance has had on my life.

DATE:	PROCEDURE REQUESTED (*Circle one*) SIGHT RESTORING SURGERY HEARING AID (*1 provided*)
SIGNATURE OF APPLICANT (parent /guardian if a minor)	

After you receive assistance would you be willing to share your experiences with the Idaho Lions Sight and Hearing Foundation and speak at events featuring Lions Club members and Foundation partners?
Yes No

PERMISSION FOR DOCTOR'S RELEASE OF MEDICAL INFORMATION

REQUIRED FOR SIGHT RESTORING SURGERIES ONLY

DOCTOR/PATIENT INFORMATION	
Doctor:	Patient Name:
Address:	Address:
City:	City:
State:	State:
Zip:	Zip:
Name of Office:	Procedure Requested:

INITIAL HERE	
	I hereby authorize the surgeon who has been selected by me (parent/guardian if a minor) to release any and all information pertinent to my case to the Idaho Lions Sight and Hearing Foundation and their representatives. I also authorize the surgeon selected to perform surgery pertaining to disease or injuries of the eyes only.
	If I am to receive assistance I understand the cost thereof as may be authorized by the Idaho Lions Sight and Hearing Foundation will be financed by them, as indicated on their authorization form bearing their authorized signatures. I agree any money 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 the authorization is for DAY OF SURGERY COSTS ONLY, which will include physician, facility and anesthesia costs only unless otherwise clearly indicated in the authorization letter. No other charges will be covered by the Idaho Lions Sight and Hearing Foundation.
	I understand that no surgery is to be performed until I have signed this form and I have received an authorization from, or authority has been given electronically, by fax or phone directly from the Idaho Lions Sight and Hearing Foundation Hearing Trustee assigned to this application. I understand that the Idaho Lions Sight and Hearing Foundation will not be responsible for any expenses if these instructions are not followed.
	I hereby absolve the Idaho Lions Sight and Hearing Foundation of any responsibility in connection with the surgery, hospitalization or postoperative care.

DATE:	PROCEDURE REQUESTED:
SIGNATURE OF APPLICANT (parent /guardian if a minor)	