



**Lions Eye Foundation of California-Nevada, Inc.**

**P.O. BOX 7999**

**San Francisco, CA 94120**

**PRESERVING & RESTORING THE GIFT OF SIGHT  
GUIDELINES AND INSTRUCTIONS FOR REFERRING PATIENTS**

**1. Patient Eligibility**

- One year of continuous residency in communities served by the Foundation
- No Health Insurance (no county, government, or private coverage; no partial Coverage, share-of-cost, or deductibles)
- Adjusted Gross Income (AGI) (line 37 on IRS Form 1040 or line 4 on IRS Form 1040EZ, or line 21 on IRS Form 1041) verified within guidelines established January 1, 2026 as follows:

Family Size	1	\$62,600
Two Income Family	2	\$84,600
Family Size	3	\$106,600
Family Size	4+	\$128,600

**2. Doctor Or Health Clinic Referral Requirements**

- It must first be determined that the patient has an eye condition requiring treatment (excluding eyeglasses and contact lenses). A referral from a doctor, optometrist, or ophthalmologist stating the patient's diagnosis is required. Lions Eye Foundation does not provide financial aid for eyeglasses or contact lenses.
- Completion of physician referral form, patient financial statement and patient release of information (must be signed by doctor, patient, or clinic authorized person accordingly).

**3. Club's Responsibility If Club Refers A Patient**

- The club must coordinate the patient referral process by contacting the Program Coordinator, Adriana Reyes-Gouvea at Tel: (415) 600-3950, Fax: (415) 369-1225, or email [Adriana.Reyes-Gouvea@sutterhealth.org](mailto:Adriana.Reyes-Gouvea@sutterhealth.org).
- With the aid of the Program Coordinator oversee the completion of physician referral form, patient financial statement and patient release of information (must be signed by doctor, patient, and club rep accordingly).
- If possible aid with transportation to and from appointments in San Francisco. LEF will reimburse clubs a portion of the mileage cost (one-way only) *after* the appointment has occurred. The transportation reimbursement request form and instructions are available on our website.
- When possible referring clubs to provide glasses after patient has completed treatment/surgery.

**4. Questions/Forms/Emergencies (retinal detachment, foreign object in eye, etc.)**

- Contact Lions Eye Foundation, Adriana Reyes-Gouvea, Program Coordinator
- Tel: (415) 600-3950 Fax: (415) 369-1225
- Email: [Adriana.Reyes-Gouvea@sutterhealth.org](mailto:Adriana.Reyes-Gouvea@sutterhealth.org).



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## **PATIENT REQUIREMENTS WHEN APPLYING**

### **1. Verification of Income**

- Verification of income must be submitted along with your application. Verification of income can be any one of the following:

1. Most recently filed federal tax return.
2. Copies of your two most recent paystubs or unemployment checks
3. Copy of government award letter.
4. Signed personal letter stating you have no income; and if applicable, stating you are living with and/or supported by family.

### **2. Health Insurance Information**

- Provide your health insurance information on the patient financial statement. Be sure to address all questions regarding insurance.



**PHYSICIAN REFERRAL FORM**  
**Lions Eye Foundation of**  
**California-Nevada, Inc.**  
PO Box 7999, San Francisco, CA 94120  
Phone (415) 600-3950 Fax (415) 369-1225

**TO SUBMIT APPLICATION:**

**Fax:** (415) 369-1225  
**Attn.:** Adriana Reyes-Gouvea

**Mail:** Lions Eye Foundation  
PO Box 7999  
San Francisco, CA 94120

**Note: Incomplete applications will delay the referral process**  
**Questions? Please call (415) 600-3950**

**TO BE FILLED OUT BY REFERRING CLINIC**

**Date:** \_\_\_\_\_

**Referring Physician:** \_\_\_\_\_

**Phone:** \_\_\_\_\_

**Address:** \_\_\_\_\_ **Fax:** \_\_\_\_\_  
Street

\_\_\_\_\_

City

State

Zip

**Patient:** \_\_\_\_\_  
Last First

**Birth Date:** \_\_\_\_\_

**Address:** \_\_\_\_\_  
Street

**Phone:** \_\_\_\_\_

\_\_\_\_\_

City

State

ZIP

**Sex** (circle one): male female **Primary Language:** \_\_\_\_\_

**Diagnosis:** (Include complete eye exam, including visual acuity, external slit lamps, Muscles, fundus exams, and most recent chart notes)

**Signed:**

\_\_\_\_\_ MD/DO/Authorized Clinic Representative



**PATIENT FINANCIAL STATEMENT**  
**Lions Eye Foundation of California-Nevada, Inc.**  
**PO Box 7999, San Francisco, CA 94120**  
**Phone (415) 600-3950 Fax (415) (415) 369-1225**

**Patient:** \_\_\_\_\_ **Birth Date:** \_\_\_\_\_  
 Last First

**Address:** \_\_\_\_\_ **Phone:** \_\_\_\_\_  
 Street  
 \_\_\_\_\_  
 City State Zip

**Emergency Contact:** \_\_\_\_\_ **Relationship:** \_\_\_\_\_  
 Name  
**Phone Number:** \_\_\_\_\_

1. Patients Current Employment (circle one): Full time Part time Unemployed Retired  
 If employed, name of employer: \_\_\_\_\_  
 If unemployed, how long since you worked? \_\_\_\_\_

2. Spouse/Partner Employment (circle one): Full time Part time Unemployed Retired  
 If employed, name of employer: \_\_\_\_\_

3. Household monthly income (Proof of income required-include copy of last two paystubs or previous year's tax return)

Adjusted Gross Income \$ \_\_\_\_\_  
 If self-employed, gross income (AGI) \$ \_\_\_\_\_

4. Do you have:  
 a. Medi-Cal or Medicaid? No Yes Card Number \_\_\_\_\_  
 b. Medicare? No Yes  
 c. Other insurance? N Yes, Name of plan: \_\_\_\_\_  
 d. Have you ever applied for Medi-Cal or Medicaid? No Yes  
 If yes, please describe: \_\_\_\_\_

5. I attest that all statements contained in this application and any accompanying documents are true and correct, with full knowledge that all statements made in this application are subject to investigation and that any false or dishonest answer to any question may be grounds for denial

\_\_\_\_\_  
 Signature of Patient or Parent/Guardian Date

**PATIENT RELEASE OF INFORMATION**  
**Lions Eye Foundation of California-Nevada, Inc.**  
**PO Box 7999, San**  
**Francisco, CA 94120**  
**Phone (415) 600-3950**  
**Fax (415) 369-1225**

**I. Explanation:** Authorization for use or disclosure of my health information is required by state and federal law.

**II. Authorization:** This authorization applies to the health information for:

Patient: \_\_\_\_\_ Date of birth: \_\_\_\_\_ I,

(patient or legal representative) \_\_\_\_\_

Authorize \_\_\_\_\_

(Name and address of entity releasing records)

to release my complete eye exam, including visual acuity, external, slit lamps, muscles and fundus exams to Lions Eye Foundation.

**I hereby authorize the Lions Eye Foundation of California-Nevada, Inc. to make any investigation concerning me and my dependents which is necessary to establish eligibility for assistance.**

**III. Expiration:** The authorization shall become effectively immediately and shall remain in effect until (enter specific date of event): \_\_\_\_\_

**IV. Restrictions:** California law prohibits the recipient from making further disclosure of your health information unless the recipient obtains another authorization from you, or unless the disclosure is permitted by law. This protection does not extend to recipients outside the state of California.

**V. Your Rights:**

- I understand that authorizing the release of this health information is voluntary. I may refuse to sign this authorization.
- I may revoke this authorization at any time. My revocation must be in writing, signed by me or on my behalf, and delivered to this address: Lions Eye Foundation, PO Box 7999, San Francisco, CA 94120. My revocation will be effective upon receipt but will have no impact on uses or disclosures made while my authorization was valid.
- I have a right to receive a copy of this authorization; the original of this document will be kept on file with Lions Eye Foundation. I may inspect and obtain a copy of the health information that I am authorizing for use or disclosure.

**VI. Signature**

Signature: \_\_\_\_\_

Date: \_\_\_\_\_

Print Name: \_\_\_\_\_