Lions Eye Foundation of California-Nevada, Inc.
P.O. BOX 7999
San Francisco, CA 94120
PRESERVING & RESTORING THE GIFT OF SIGHT

GUIDELINES 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 (AGI1) verified within guidelines established January 1, 2024 as follows:

Family Size	1	$ 58,320
Two Income Family	2	$ 78,880
Family Size	3	$ 99,440
Family Size	4+	$ 120,000

[1]from line 37 on Form 1040, or line 4 on Form 1040EZ, or line 21 on Form 1040A

2. **Doctor Referral**
   - It must first be determined that the patient has an eye condition requiring treatment (excluding eye glasses and contact lenses). A referral from a doctor stating the patient's diagnosis is required. Lions Eye Foundation does not provide financial aid for eye glasses or contact lenses.

3. **Club's Responsibility**
   - Completion of physician referral form, patient financial statement and patient release (must be signed by doctor, patient, and club rep accordingly).
   - If possible provide assistance for 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
   - Web: www.lionseyefoundation.com

Lions Eye Foundation of California-Nevada, Inc.
P.O. BOX 7999
San Francisco, CA 94120
PRESERVING & RESTORING THE GIFT OF SIGHT

REQUIREMENTS WHEN APPLYING

1. **Verification of Income**
   - Verification of income must be submitted along with your application. Verification of income can be any 1 of the following:

     1. Most recently filed federal tax return
     2. Copies of your two most recent pay-stubs 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. **Social Security Number (SSN)**
   - You must also include your social security number (SSN) if you have one. If you do not have a SSN please write "no SSN". Even without a SSN you are still eligible for LEF services.

3. **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: _____ **Birth Date**: _____
Last First

Address: _____ **Phone:** _____
Street

_____
City State Zip

Sex (circle one): male female **Primary Language**: _____

Diagnosis: (Include complete eye exam, including visual acuity, external slit lamps, muscles and fundus exams)

Signed: _____ MD/DO

Sponsoring Lions Club: _____ **District**:_____

I verify that I have screened this patient with regard to the financial need and have found the patient is eligible for Foundation assistance:

Authorized by: _____ Title: _____
Print Name

Phone: _____

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

_____ **Social Security Number**: _____
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 pay stubs 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? No 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 and affiliate Lions Club.

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: _____