The Melvin Clack Fund Advisory Committee

An Advisory Committee to the Lions Sight & Hearing Foundation

The Melvin Clack Fund Advisory Committee
c/o Steve Mortenson, M.D.
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Application for Eye Care Assistance

APPLICANT INFORMATION:

Applicant: _____ Sex: Male / Female
(Name; please print clearly) (Circle one)

Address: _____ Email Address: _____

City: _____ Zip Code:_____ Phone: _(___)_____

Date of Birth_____ Age:_____ SS# _____

Contact Person: _____ Phone: _(___)_____

Address: _____

City: _____Zip Code: _____ Cell Phone: _(___)_____

Number of Persons in Household: Adults: ____ Children:____ Who referred you?_____

Amount you can pay towards your care: $_____ ***(Financial information must be submitted with app)***

MONTHLY BUDGET:

Income: Husband:$_____ Wife$_____other:$_____

please list ALL other income to include everyone in household

_____

(Example- SSI,SS,and Food stamps,ADC,Interest,Dividends,Royalties,401K,retirement Funds etc.)

TOTAL MONTHLY INCOME(please total all of the above) $ _____

Please List ALL monthly expenses:

Rent / Mortgage Payment $ _____

Utilities (phone, gas, water, electric) $ _____

Food $ _____

Insurance (Auto, Health Life etc.) $ _____

Installments Payments dates

Auto (Include final date) _____ $ _____

Loans/credit cards _____ $ _____

Other monthly expenses (child support / medical, etc.) $ _____

TOTAL MONTHLY EXPENSES $ _____

Please include any unusual and extraordinary expenses on a separate sheet. If you have NO income or expenses, please attach a separate sheet explaining your living arrangements.

INSURANCE: Provide the name of your insurance provider: _____

QUESTIONNAIRE:

1. Have you visited a doctor concerning your eyes? Yes / No (Please circle one)

   If "yes" Name of Doctor: _____ Phone: _(___)_____
   Diagnosis:_____

   (Include copies of any Information you have concerning your condition)

2. If you are applying for financial assistance for an eye exam or the purchase of corrective lenses have you applied to the local Lion's Club for assistance?

   Yes / No (please circle one)

3. Are you receiving assistance for your eye care needs from the Lion's Club or any other organization?

   Yes / No (please circle one)

4. If yes, please provide the name of the organization and the amount of financial assistance.

   Name: _____ Amount:_____

PURPOSE:

Please describe the eye care needs for which you are requesting assistance (e.g. eye exam, eye surgery, corrective lenses) and the eye conditions or visual limitations you are seeking to treat, cure, or correct:

_____

_____

_____

_____

_____

_____

_____

(Please attach additional pages as necessary)

Notice to Diabetics: You must have a letter from your attending physician regarding the status of your diabetes before any surgical procedure is approved.

Important: ***You must enclose the first two{2) pages of last year's federal income tax return if you filed. If You did not file, attach copies of proof of income (W2, check pay stubs, etc.).***

The Lions Sight & Hearing Foundation has not, directly or through the Melvin Clack Fund Advisory Committee, granted any authority, express or Implied, to any person, organization, or government agency, Including, but not limited to, any person, referral organization, Lions Club or Physician from whom you may have obtained this application for assistance, to act on behalf of or to otherwise bind the Lions Sight & Hearing Foundation or, specifically, the Melvin Clack Fund Advisory Committee, In any manner whatsoever. Neither this application form, nor your receipt of this application from any such source Is a representation from the Lions Sight & Hearing Foundation of any authority, actual or apparent in such source. All such expressions of authority are hereby disclaimed. You should direct any questions regarding the assistance available through the Melvin Clack Fund Advisory Committee, eligibility for such assistance. And this application for assistance directly to the Melvin Clack Fund Advisory Committee at the address and/or phone number set forth on this form. There is no application fee associated with the submittal to and review by the Melvin Clack Fund Advisory Committee.

RELEASE:

I, for myself, my heirs, personal representatives, executors, administrators, and assigns, and on behalf of the patient, if the patient is other than myself and I am the responsible party for the patient, waive, release and forever discharge the Lions Sight & Hearing Foundation (including specifically, but not limited to, the Melvin Clack Fund Advisory Committee), the Lions Clubs of Arizona, and each of their respective officers, directors, agents, representatives, successors and all cooperating entities and individuals from all claims, losses, and damages which now exist or may hereafter arise in connection with my and/or the patient's acceptance of assistance from the Melvin Clack Fund Advisory Committee or corresponding eye care paid for through such assistance from the Melvin Clack Fund Advisory Committee.

To the best of my knowledge, I represent the information on this form to be correct. I understand that any false statements are grounds for refusal of assistance. I acknowledge and understand this release thoroughly and authorize any service provider contacted by the Lions Sight & Hearing Foundation, acting through its Melvin Clack Fund Advisory Committee, to release to the Melvin Clack Fund Advisory Committee any information required.

Signature: _____ Date: _____

For patients / applicants under 18 years of age:

Any patient under 18 years old MUST have the following authorization signed by the patient's parent or legal guardian before being the patient can receive any assistance.

I, the undersigned responsible person, have read and understand the foregoing request for assistance. I am willing to accept the services provided by the Lions Sight & Hearing Foundation through the Mel Clack Fund Advisory Committee for this minor child. After you have read all of this form please sign and date below:

Signature: _____ Date: _____

Relationship to Applicant:----------

Person in Family/Household	Poverty Guidelines		
1	$11,880/yr	$990/mo	$5.71/hr
2	$16,020/yr	$1,335/mo	$7.70/hr
3	$20,160/yr	$1,680/mo	$9.69/hr
4	$24,300/yr	$2,025/mo	$11.68/hr
5	$28,440/yr	$2,370/mo	$13.67/hr
6	$32,580/yr	$2,715/mo	$15.66/hr
7	$36,730/yr	$3,061/mo	$17.66/hr
8	$40,890/yr	$3,407/mo	$19.66/hr

2016 POVERTY GUIDELINES FOR THE 48 CONTIGUOUS STATES AND THE DISTRICT OF COLUMBIA

For families/households with more than eight people, add $4,160/yr ($346/month) for each additional person.