PATIENT FINANCIAL ASSISTANCE APPLICATION ENCLOSED

In order for the Plainfield Lions Club to evaluate your financial situation, all questions **MUST** be answered if this application is to be considered. Information revealed herein will be kept strictly confidential and will be used solely for the evaluation of your request for financial assistance.

Please return the following information within thirty days so that we may process your application:

1. The completed Charity Care Application attached to this letter.
2. Proof of your income, your spouse's income, and proof of income for anyone living with you of working age.
    a. Most recently signed income tax form, complete with a copy of W-2(s), 1099, etc. If you did not file taxes verification of non-filling from the IRS is required. (IRS-1-800-829-1040)
    b. A copy of two (2) or more of your most recent pay stubs (or a letter from your employer that is notarized or on company letterhead verifying gross income)
    c. Proof of alimony, child support, unemployment, pension, etc.
    d. Proof of Social Security income, if applicable.
3. **If you are unable to work due to an illness or disability, a letter from your physician confirming your inability to work is required. Form attached.**
4. If you receive no income and are being supported by relatives or friends, a **notarized** letter explaining these arrangements is required. The letter must be signed by any person(s) supporting you financially.
5. If you, your spouse, or anyone of working age living with you is unemployed, a **notarized** letter is also required stating length of unemployment, along with the name and relationship to you.
6. If you or anyone in your household receives food stamps, you must provide a copy of your most recent award letter or verification letter.
7. A copy of your denial letter from Medicaid indicating you are not eligible for the Medicaid program.
8. If employed, you must provide a letter from employer (on company letterhead) stating if they do or do not offer vision insurance to their employees.
9. Please mail this completed application to:

    Plainfield Lions Club
    Lion Worth Donaldson
    1000 Creekside Lane
    Plainfield, IN 46168

* FALSIFYING INFORMATION ON THE FINANCIAL ASSISTANCE APPLICATION WILL RESULT IN US TAKING BACK ANY FINANCIAL ASSISTANCE PROVIDED TO YOU UP TO THAT POINT AND MAKE YOU FULLY RESPONSIBLE FOR YOUR VISION BILLS. THIS ALSO APPLIES TO CHARITY/DISCOUNTED CARE RENEWALS.

SECTION 1: PATIENT INFORMATION

Name: _____
First Name Middle Initial Last Name

Gender: Male or Female Date of Birth: _____ Age: _____

Address: _____

City: _____ State: _____ Zip _____

Home Phone: _____ Cell Phone: _____

Applicant's Occupation: _____

Name Of Employer: _____

I have been a resident of _____ County for _____ years.

If application is for a child: Grade: _____ School _____

Parents Name:_____

Number of people in household: _____

My last eye exam was on _____ (date) at _____(location)

Name of person submitting request: _____ Date: _____

List all persons residing in household:

	NAME	AGE	DISABLED?	ANNUAL INCOME
Head of Household	_____	_____	Y/N	_____
Spouse	_____	_____	Y/N	_____
Children or Other Dependents	_____	_____	Y/N	_____
	_____	_____	Y/N	_____
	_____	_____	Y/N	_____
	_____	_____	Y/N	_____

SECTION 2: INCOME AND EXPENSES

INCOME		EXPENSES	
DESCRIPTION	MONTHLY INCOME	DESCRIPTION	MONTHLY EXPENSE
List monthly household income from any of these sources:			
Applicant Wages	$_____	Rent/House Payment	$_____
Employer Name	_____	Food	$_____
Spouse/Domestic Partner Wages	$_____	Utilities	$_____ (Elec./Water/Phone/Gas)
Employer Name	_____	Repairs	$_____ (Car or Home)
Dividend and Interest	$_____	Installment Loans - List:	$_____
Rental Income	$_____	_____	
Pension Income	$_____	Car Payment	$_____
Child Support (Income)	$_____	Other Charge Accounts	$_____
Alimony (Income)	$_____	Visa/Master Card	$_____
Additional Income	$_____	Cell Phone/Pager	$_____
Social Security Benefits	$_____	Cable TV	$_____
V.A. Benefits	$_____	Child Support	$_____
Welfare	$_____	Alimony	$_____
Others - List	$_____	Child Care	$_____
		Medical Transportation	$_____
		Education (Student only)	$_____
		Monthly Medication(s)	$_____
Total Income Per Month	$_____	Total Expenses/Monthly	$_____

SECTION 3: ASSETS

DESCRIPTION	VALUE AMOUNT	DESCRIPTION	
Checking Account	$_____	Car	$_____
Bank Name _____			
Savings Account	$_____	Others - List:	$_____
Bank Name _____		_____	$_____
IRA	$_____	_____	$_____
Insurance Policy		_____	$_____
Home	$_____	Total Assets	$_____

I understand that the information I submit is subject to verification by the Plainfield Lions Club.

I certify under the statues of perjury that the information on these papers is true and correct, and that I do not have the financial means to pay for vision care rendered to the above patient.

**My signature on this application verifies that if I am entitled to any other medical benefits, including, but not limited to, a supplemental insurance policy, that I will provide the Plainfield Lions Club with this information. Should I choose not to give any information regarding my supplemental insurance carrier, my application for assistance may be denied and I may be responsible for the total amount of bills accrued.

I hereby authorize any individual or organization to release to the Plainfield Lions Club any information necessary to confirm statements made in this application. In consideration of any aid, which may be granted, I agree to hold the Plainfield Lions Club harmless from any injury resulting from treatment paid by them. I ALSO UNDERSTAND THAT THERE ARE NO EXPRESSED OR IMPLIED SERVICES OTHER THAN POSSIBLY AN EXAM AND GLASSES.

Signature of responsible party _____ Date signed _____

SECTION 4: INSURANCE

1. If unemployed: How long? Y/N
   Were you removed from work by a physician? _____
   Comments: _____

2. Have you applied for Social Security Disability? Y/N
   Date application submitted _____
   Comments: _____

3. Have you applied for Medicaid? Y/N
   Approved _____ Denied _____ Pending _____
   Comments: _____

4. Have you or your spouse ever served in the military? Y/N
   Have you applied for Veterans benefits? Y/N
   Comments: _____

5. Do you have insurance? (check box)
   - ☐ Private Insurance
   - ☐ Vision Insurance
   - ☐ Medicare
   - ☐ Veteran's
   - ☐ Vision Insurance
   - ☐ None
   - ☐ Traditional Medicaid
   - ☐ Healthy Indiana Plan (HIP)
   - ☐ Healthy Indiana Plan Plus (HIP Plus)
   - ☐ Healthy Indiana Plan
   - ☐ Hoosier Healthwise

You are required to check with your insurance provider regarding vision coverage within your plan. If you do not have insurance, you are required to seek out insurance eligibility before applying with your Lions Club.

I **certify under the statues of perjury that the information on this page is true and correct, and that I do not have the financial means to pay for vision care rendered.**

Falsification of any portion of this application may result in the denial of assistance.

Signature of responsible party _____ Date signed _____

SECTION 5: PROGRAM GUIDELINES

Please read this information carefully to understand the benefits and limitations of the Plainfield Lions Club Eyeglass Assistance Program. Should you move forward with the process through the Program, it is important that you understand and agree to the following guidelines that affect the use of the authorization. Please initial on each line to indicate you read and understood the item.

The following services ONLY are covered by the authorization:
A routine eye/vision exam from a Optometrist at the assigned office.
If you have any medical eye problems the exam should be covered by your medical insurance. Single vision, Lined Bifocal or Lined Trifocal lenses in plastic.
Eyeglass frame ONLY within the program limitation

_____ **Initial Here**

Upgrades of any kind (such as different frames, tints or other lens options) are NOT allowed and will INVALIDATE the authorization.
Do not ask for a frame not covered within the program, any tints, photochromic lenses (Transitions), high/mid index lenses, antireflective coatings, extra wide bifocals/trifocals,or non-lined bifocals/trifocals.
Do not accept upgrades if offered any by the doctor's office acceptance will INVALIDATE the authorization and then you be responsible for paying in full.

_____ **Initial Here**

You cannot transfer use of your authorization to another person. It is for your use ONLY.
The authorization expires 30 days from the issue date.

_____ **Initial Here**

Please keep the appointment you make with the Optometric Office that you were assigned.
If you cannot make the appointment, call the doctor's office to cancel within reasonable time.
If you do not call to cancel and miss your appointment, you may INVALIDATE your authorization.

_____ **Initial Here**

I agree to the above rules and limitations regarding the Plainfield Club Eyeglass Assistance Program. I understand that if I do not follow these guidelines or provide false or inaccurate information on this application I may invalidate my authorization and assume the financial responsibility for your services.

Signature of responsible party _____ Date signed _____