Lions Saving Sight use ONLY

CASE# _____

DATE OF BIRTH: ___ / ___ / ___

DATE CASE OPENED: ___ / ___ / ___

DATE CASE CLOSED: ___ / ___ / ___

Lions Saving Sight
The Florida Lions Foundation

PROJECTS FORM

Client Information:

Last Name: _____ First Name: _____ DOB: ___ / ___ / ___

Address: _____ City: _____ State: _____ Zip Code: _____

Cell Phone: _____ email:_____

District: _____ Club/Referral Source _____

Contact Person Name: _____

E-Mail: _____ Cell phone: _____ Other: _____

Is Applicant a US Citizen? Yes/No ____ Resident of Florida? Yes/No_____ VISA/Green Card? Yes/No_____

Applicant Present Address:

_____

City _____ State_____ Zip_____How long at present address? _____

Cell Phone: _____Home Phone: _____E mail address: _____

Work /Employment History: Type of Work? _____Working now? Yes/No_____
Date last worked:_____

Medical History

Did applicant visit OD/MD general eye exam and receive a diagnosis? Yes/No _____ *Please attach report*

Diagnosis or Treatment recommended: _____

Is Applicant Diabetic: Yes/No_____ If yes last A1C: _____ Date:_____

Any Surgeries in last 6 months? Yes/No _____ List any recent surgeries _____
Any past issues of blood clots? Yes/No _____ Cardiac/Heart Issues? Yes/No____
Explain: _____

Monthly Household Income and Financial Assets : Total Household Income ALL sources: $_____
Monthly Expenses : Rent/Mortgage $_____ Number in Household_____
Financial Comments:

_____
_____

Medical Insurance Information :
Do you have Health Insurance? Yes / No _____ *If Yes, please copy front and back of medical card(s) and attach with this form*
Has coverage been denied? Medicare Yes/No_____ Medicaid Yes/No _____ Other _____
***Attach Denial Copy**
Did you apply for Medicare or Medicaid and are waiting for a response? Yes/No _____

If under 65 years old and not disabled:
Did you apply for Division of Blind Services support? Yes/No _____ If denied, Date: _____
***Attach Denial Copy**

Applicant Statement of Understanding

Our partnering physicians and surgeons are dedicated with providing quality, successful eye care for their patients. To have the best possible outcome, you must be in complete compliance with your doctor's orders regarding any pre-op and post-op instructions, use of eye medications, follow-up visits, and other instructions from staff. Keeping follow-up appointments is extremely important. If you fail to keep a post-op appointment, you will be less likely to have a successful outcome, and you are putting your eyesight at risk.

If you are not able to be compliant, for any reason, Lions Saving Sight, the surgery center, the doctor and staff, will not be responsible for any complications, poor outcomes, or failures that may result. The doctor and/or the surgery center has the right to deny service for a second eye surgery if you are non-compliant with the first eye surgery. Lions Saving Sight and our partnering physicians want the very best for your eye care so your goal must be the same by following all instructions.

_____

I have read and understand the above, and if I accept treatment or surgery from Lions Saving Sight, I agree to be fully compliant with my treatment plan including attending all post-op visits when scheduled, all medications as required, and all plans of care specific to my case.

I hereby certify that all information provided on this application for Financial Assistance is correct and give Lions Saving Sight permission to use this information including applicable medical records to assist with determination of medical and financial eligibility.

Applicant Name Printed: _____

Applicant Signature: _____Date: _____

Applicant Checklist of attachments required with application:

_____ Driver's License, Passport, or Visa copy, must be clear and legible

_____ Health Insurance Card(s), front and back

_____ Medical records pertaining to Eye condition

_____ Application with all areas completed and signed

For Lions Saving Sight - DO NOT FILL IN BELOW Completed by Director of Operations or Designee

Project Form Page 3- Lions Saving Sight Admin use ONLY

CASE# _____ **Patient Name**_____

DOB: ____ / _____ / _____ **Procedure**_____**Referral**_____

DATE CASE OPENED: _____ / _____ / _____ **DATE CASE CLOSED:** _____ / _____ / _____

Is Applicant Diabetic: Yes/No_____ If yes-last A1C: _____ Date:_____

District: _____ **Club/Referral Source** _____

(Physician Partner Information)

Doctor Name: _____ **Phone:** _____

Procedure Facility: _____ City:_____

Phone: _____

Procedure:_____ Eye L/R_____ CPT Code:_____

ACTUAL AMOUNTS PAID

Surgeon $_____ Anesth $_____ Facility: $_____ Misc: $_____ Medications: $_____

Date of Service: _____/_____/_____

Surgeon Paid: $_____ Surgeon Date: _____ Check1 #: _____

Anesth Paid: $_____ Anesth Date: _____ Check2 #: _____

Facility Paid: $ _____ Facility Date: _____ Check3 #: _____

Misc Paid: $ _____ Misc. Date: _____ Check4 #: _____

Medications: $ _____

Approved by: _____

Director of Operations
Judi Seltzer, MS, BSN, RN, CNOR
Email: lionseltzerjudi@gmail.com
1315 Sterling Point Drive, Gulf Breeze, FL 32563
Cell: 850-876-0005

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