Georgia Lions
Lighthouse Foundation

Dear Applicant:

Thank you for contacting the Georgia Lions Lighthouse Foundation Vision Program for assistance with either your eye exam and/or eyeglasses. We are able to provide people who are either uninsured or underinsured with exams and brand new eyeglasses. Please note that the Lighthouse is an administrative office only, we do not provide exams here, nor do we make the glasses here.

After you have mailed back your application to the Lighthouse, we will either approve or deny your application. Once that occurs, you will receive a letter in the mail stating the next step to receive your exam and/or glasses. Please wait approximately 3 weeks to hear a response from the Lighthouse. After that, you may call the Lighthouse regarding the status of your application.

Make sure you fill out the application form completely and include the required documents. Forms that are not completed could cause your application to be delayed or denied. Make a copy of the application for yourself and mail the original to the:

Georgia Lions Lighthouse Foundation
1775 Clairmont Rd
Decatur, GA 30033

1. Identification (Please provide a copy of one of the following):

a. GA Driver's License
b. State of GA Identification Card
c. GA birth certificate, **or**
d. Voter's Registration Card

2. Proof of Residency (Please provide a copy of one of the following):

a. Lease Contract (if renting)
b. Mortgage Statement if you own your home
c. Referral from shelter or transitional home, **or**
d. Referral from nursing home

3. Proof of Income: Household income must include all persons residing at the applicants address.

Please provide a copy of the following information for everyone living at the applicants address:

Last years Tax Return

AND/OR

any of the following that apply

a. Three current pay check stubs
b. Social Security Administration Award Letter
c. Food Stamp Papers from Family & Children Services (award summary notification)
d. Unemployment claim, if unemployed – wage inquiry statement from GA Dept. of Labor
e. Information indicating the applicant is receiving TANF, Social Security Disability, Pension, Retirement, Veterans Administration Benefits, or any other sources of income
f. Last three months of bank statements **and/or**
g. Letter from nursing home stating income benefits

4. Copy of your current prescription. Medicaid and Medicare usually cover an annual vision exam. Your prescription needs to be less than one year old and signed by a doctor.

5. Authorization of Release of Information: Complete this form only if you want someone else besides yourself to contact the Lighthouse Foundation on the status of your sight services application. An example would be the applicant's spouse or sibling.

SIGHT SERVICES: APPLICANT GENERAL INFORMATION

Please answer all the questions.

1. Applicant's Name: _____
First Middle Last
2. Name of Parent (if applicant is a child): _____
First Middle Last
3. Address: _____

4. City, State, Zip Code: _____

5. County: _____ 6. Sex (M or F): _____

7. Social Security Number: _____-_____-_____ 8. Date of Birth ____/____/____

9. Home Phone Number: _____ 10. Emergency Phone Number: _____

11. Email Address: _____

12. Are you employed? (**Yes or No**): _____
13. If no, are you actively seeking employment? (**Yes or No**) _____

14. If applicant does not work, please circle all that apply:

Disabled(only if you receive SSDI) Not Able Retired Lost Job Other

15. How long have you been a legal Georgia resident? _____

16. Race (White, African American, Hispanic, Other): _____

17. Insurance: Please circle every type of each insurance you have.

Medicare Medicaid VA Peachcare Other

18. State reasons why you cannot afford an eye exam or eyeglasses? _____

_____

19. Marital Status: (Married, Single, Divorced, Separated, Widowed) _____

20. Names of **DEPENDENTS** living at the same address as you. ****(Please include proof of residency as instructed on page one)** A dependent is someone that you support financially.**

Name	Relationship	Age	Name	Relationship	Age
1)_____			2) _____		
3)_____			4) _____		
5)_____			6) _____		

21. What service are you applying for at this time? (circle one or both)

Eye Exam Eyeglasses

SIGHT SERVICES: FINANCIAL INFORMATION

22. List monthly income received by you and all persons living at your address. ****(Please include proof of monthly income as instructed on page one)**** If person works list Employer and Monthly Salary. List all Benefits received by each person in the household: Supplemental Security Income (SSI), Social Security Disability (SSDI), Social Security, Food Stamps, Welfare, Veteran's Benefits (VA), Pension, Retirement Benefits, Child Support, Unemployment Claim, or Other Income.

Name **Source of Monthly Income** **Amount($) of Monthly Income**

1) _____

2) _____

3) _____

4) _____

5) _____

6) _____

23. **List monthly expenses:**

a) Rent or Mortgage: $_____ b) Gas(home): $_____ c) Power: $_____

d) Water/Sewage: $_____ e) Food $_____ f) Medicine $_____

g) Phone: $ _____ h) Auto Payment $ _____ i) Credit Cards $ _____

j) Insurance (Life, Health, Car):$_____ k) Other expenses:$ _____ l) Medical Debt: $_____

SIGHT SERVICES: LIGHTHOUSE STATEMENT

Applicant Must Read and Sign This Statement:

"I fully understand Lighthouse services are limited to legal GA residents unable to pay for, or receive from other sources this assistance. In consideration of these services, I release and discharge all persons rendering such services from any claims I may have arising from services rendered. I am aware that the Lighthouse will not pay for any eyeglasses billed to me prior to approval of this application. I also understand my application may be reviewed by a Lions Club, Lighthouse Providers, and/or the Lighthouse staff. ALL INFORMATION ON AND ATTACHED TO THIS APPLICATION IS TRUE AND CORRECT TO THE BEST OF MY KNOWLEDGE."

_____ _____

Signature of Applicant (or parent if applicant is a child) Date

_____ _____

Witness (if applicant signs with an "X") Date

SURVEY

Thank you for completing this survey. The results from this survey will allow us to assess the services you receive. This survey will take approximately 10 minutes to complete.

Name: _____ **Date of Birth:**_____

1. What type of service are you applying through the Lighthouse for?
_____1 Eyeglass Only
_____2 Exam Only
_____3 Exam and Eyeglass

If you answered yes to eyeglass only, please skip questions 2-7

2. How much difficulty, if any, do you have in recognizing a friend across the street? Would you say-
_____1 No difficulty
_____2 A little difficulty
_____3 Moderate difficulty
_____4 Extreme difficulty
_____5 Unable to do because of eyesight
_____6 Unable to do for other reasons

3. How much difficulty, if any, do you have reading print in newspapers, magazines, recipes, menus, or numbers on the telephone? Would you say—
_____1 No difficulty
_____2 A little difficulty
_____3 Moderate difficulty
_____4 Extreme difficulty
_____5 Unable to do because of eyesight
_____6 Unable to do for other reasons

4. When was the last time you had your eyes examined by any doctor or eye care provider?
_____1 Within the past month (anytime less than 1 month ago)
_____2 Within the past year (1 month but less than 12 months ago)
_____3 Within the past 2 years (1 year but less than 2 years ago)
_____4 2 or more years ago
_____5 Never

5. What is the main reason you have not visited an eye care professional in the past 12 months?
_____1 Cost/insurance
_____2 Do not have/know an eye doctor
_____3 Cannot get to the office/clinic (too far away, no transportation)
_____4 Could not get an appointment
_____5 No reason to go (no problem)
_____6 Have not thought of it
_____7 Other

6. How often do you <u>think</u> you should have your eyes examined?
_____1 Every 6 months
_____2 Every year
_____3 Every 2 years
_____4 Every 5 years
_____5 Don't know

7. When was the last time you had an eye exam in which the pupils were dilated? This would have made you temporarily sensitive to bright light.
_____1 Within the past month (anytime less than 1 month ago)
_____2 Within the past year (1 month but less than 12 months ago)
_____3 Within the past 2 years (1 year but less than 2 years ago)
_____4 2 or more years ago
_____5 Never

8. Do you have any kind of health insurance coverage for eye care?
_____1 Yes
_____2 No
_____3 Don't know / Not sure
_____4 Not Applicable (Blind)
_____5 Refused

9. If you answered yes to #8, what are those services?
_____1 Medicare
_____2 Medicaid
_____3 VA Insurance
_____4 Private Insurance
_____5 Not applicable

10. Do you think your life will change in any way after receiving an eye exam and/or glasses from the Lions Lighthouse Foundation?

11. Have you ever worn eyeglasses before? How long have you worn them for?

12. If you have worn eyeglasses in the past, what is currently wrong with them?

13. How did you hear about the Georgia Lions Lighthouse Foundation?

SIGHT SERVICES: AUTHORIZATION FOR RELEASE OF INFORMATION

This form should only be completed if the applicant wants someone else to contact the Lighthouse about their sight services application.

I hereby request and authorize: _____
(Name of Person that the Applicant wants to Obtain their Private Health Information)

_____
Address of above Named Person

_____
City, State, Zip Code

to obtain from: **Georgia Lions Lighthouse Foundation**
1775 Clairmont Rd
Decatur, GA 30033

the following types of information from my records (and any specific portion thereof):

_____

For the purpose of: _____

I understand that the Federal Privacy Rule("HIPPA") does not protect the privacy of information if re-disclosed, and therefore request that all information obtained by this person or agency be held strictly confidential and not be further released by the recipient. I further understand that my eligibility for Lighthouse services is not conditioned upon my provision of this authorization. I intend for this document to be a valid authorization conforming to all requirements of the Privacy Rule and understand that my authorization will remain in effect for: (Please Check One)

____ninety (90) days until I specify an earlier expiration date here: _____

____one (1) year

____the period necessary to complete all transactions on matters related to services provided to me. I understand that unless otherwise limited by state or federal regulation, and except to the extent that action has been taken based upon it, I may withdraw this authorization at any time.

_____ _____
Signature of Applicant (Person Applying for Sight Services) **Date**

_____
Signature of Witness (Title of Relationship)

_____
Signature of Authorized Representative
(Person that has the right to Applicants Private Health Information)