FORT BRAGG LIONS CLUB
Patient Application/Data Form
(For Local Eye Care Assistance Program)

Patients must fill in all requested information on both sides of this form. Incomplete applications will be denied and/or delay assistance. *Physical address* **must** be filled in, to verify residence. If you do not receive mail at that address, be sure to fill in the mailing address, as well. Please note: **The assistance program will *only* cover basic care and standard Altair frames. We will not cover designer frames or "transition" sunglasses. We follow the guidelines of VSP Choice Network Provider Service. Applications will be processed within 5-7 days of receipt. If this is an emergency, please leave a message at 707-961-1727 or email: fblions@mcn.org**

PATIENT NAME:_____

(circle) MALE FEMALE DATE OF BIRTH_____

PHYSICAL ADDRESS_____
How Long:
___yrs___months _____

MAILING ADDRESS _____

_____

HOME PHONE _____

CELL PHONE _____

ALTERNATE PHONE _____

MEDICAL INSURANCE INFORMATION:
(please circle **all** insurance and/or assistance programs you currently are covered with)

INSURANCE COMPANY NAME_____ **POLICY #**_____

CMSP **MEDI-CAL** **MEDICARE**

OTHER:_____

If you are being referred by a Physician/Clinic and/or agency, please list:

AGENCY/PHYSICIAN REFERRING
_____ _____

AGENCY/PHYSICIAN CONTACT PERSON
_____ _____

AGENCY/PHYSICIAN PHONE
_____ _____

Continued on other side….

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Please provide information on your circumstances.

1. What is your household income?
___a) Under $10,000 annually
___b) $10,000—$20,000 annually
___c) $21,000—$30,000 annually
___d) $31,000—$50,000 annually
___e) Over $51,000 annually

2. How many family members currently reside with you? ____adults ____kids

3. Why do you need assistance?

_____

_____

_____

4. Do you currently see an eye care Optometrist/Ophthalmologist ?
YES____ NO ____ If yes, Name:_____
If no, who would like to go to for eye care?_____

5. What are you requesting: EXAM ____ GLASSES____ OTHER ____

6. What is the cost? $_____

7. Have you received assistance from the Fort Bragg Lions before?
Yes____ No____ - if yes date:_____

8. Will this be a LOAN_____ GRANT _____
We hold fundraising events to raise money for our eye care program.
Would you be interested in volunteering during one (or more) of our events?
YES_____ NO_____

Please submit this *completed* form to the Fort Bragg Lions.

Mail: Fort Bragg Lions
EYECARE REQUEST
P.O. Box 1547
Fort Bragg, CA 95437

-or-

*****Drop off application at the**
Lions Hall
430 E. Redwood Ave
Ft. Bragg

*****If dropping off at the Hall, be sure to write on envelope EYECARE REQUEST and the date. Place in mail slot in the door located to the right of the main doors.**

<u>INCOMPLETE applications will be either denied and/or delay assistance</u>. Please be sure ALL information is filled out accurately.

Do not write below this line

Date contacted: _____App Sent:_____Initials___ App Rec'd:_____Initials___

Committee referral: YES____ NO____ Authorized _____ Denied _____

Physician:_____ Date Authorized:_____ Amount $_____

Date bill received:_____ Date bill paid:_____

Comments:_____

_____