Mission: To preserve and restore the gift of sight by providing free ophthalmic examinations, operations, and medication to the less fortunate members of our community.

Who receives services and eligibility?
Members of the community who are served through LEF
- Over 18 yrs of age - proof of one year’s continuous residency within LEF community and legal residency
- Under 18 yrs of age - proof of one year’s continuous residency within LEF community*
- Patients with NO insurance/coverage for eye surgical care.
- Income (this is based on NET INCOME)

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<tr>
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<tbody>
<tr>
<td>Single Person/Married Couple</td>
<td>$22,800</td>
</tr>
<tr>
<td>Single Parent/Parents with One Child</td>
<td>$25,300</td>
</tr>
<tr>
<td>Single Parent/Parents with Two Children</td>
<td>$27,600</td>
</tr>
<tr>
<td>Single Parent/Parents with Three Children</td>
<td>$30,000</td>
</tr>
<tr>
<td>Add $2,400 for each additional child</td>
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</tbody>
</table>

What LEF does?
Offers free
- Ophthalmic examinations
- Operations
- Medication
- Provide glasses after patient has complete treatment/surgery
- Complete Financial Statement, and
- Patient Referral Form

When can a patient receive services?
With proof of a Doctors Referral that determines a patient’s need for eye treatment and care. (Excludes eye glasses and contact lenses)

Where can a patient receive services?
The patient receives all serves at the San Francisco Office; money for transportation to and from appointments is provided by LEF.

Questions or Emergency cases:
Call/contact Mark Paskvan at
Tel. (415) 600.3950
Fax (415) 600.3949
E-Mail: paskvam@sutterhealth.org

*Santa Cruz County is a community served by LEF.
QUICK LIST FOR REFERRING PATIENTS

1. Patient Eligibility

- If over 18 years of age – one year’s continuous residency in the communities served by the LEF AND must be a legal resident of the United States.

- Under 18 years of age – one year’s continuous residency in the communities served by the LEF.

- Income (this is based on NET INCOME)
  
<table>
<thead>
<tr>
<th>Category</th>
<th>Income</th>
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<tbody>
<tr>
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</tbody>
</table>

- Patient has no insurance/coverage for eye surgical care.

2. Doctor Referral

- It must first be determined that the patient does indeed have an eye problem that requires treatment and care (excluding eye glasses and contact lenses). A referral from a doctor stating the patient’s diagnosis is required.

3. Club’s Responsibility

- Completion of patient financial statement and patient referral form (must be signed by doctor, patient and club representative).

- Provide money for transportation to and from appointment in San Francisco.

- Provide glasses after patient has completed treatment/surgery.

4. Questions: Call/contact Mark Paskvan tel (415) 600-3950; fax (415) 600-3949; e-mail paskvan@sutterhealth.org.

- Emergency cases (retina detachments and foreign object in eye), call Mark rather than completing the forms. It can be done by phone!
PATIENT FINANCIAL STATEMENT AND APPLICATION
FOR EYE CARE AND TREATMENT THROUGH SPONSORSHIP OF THE

Lions Eye Foundation
of California – Nevada,
Inc.

MAILING ADDRESS: P.O. BOX 7999, SAN FRANCISCO, CA 94120
(revised 1/1/93)

Patient's Name: __________________________ Telephone: (_____)
Address: ________________________________ Date of birth: ________________

Sex: M ______ F ______

If patient is a minor, the following information refers to parent or guardian:

1. Dependent: Name, Age, Relationship
2. Dependent: Name, Age, Relationship
3. Dependent: Name, Age, Relationship
4. Dependent: Name, Age, Relationship

Financial Information of Patient or Responsible Party:

1. Current Employment:
   Name of Employer: __________________________ Telephone: (_____)
   Address: __________________________ Your Driver's Lic. #: __________________
   How long Employed: __________________________ Soc. Sec. #: __________________

2. Spouse Employment:
   Name of Employer: __________________________ Telephone: (_____)
   Address: __________________________ Your Driver's Lic. #: __________________
   How long Employed: __________________________ Soc. Sec. #: __________________

3. If unemployed, how long since you have worked:

4. If retired, date of retirement:

5. Monthly Income:
   Source: Salaries and Wages
   Gross Amount: __________________
   Source: __________________
   Gross Amount: __________________
   Total Gross Income: __________________ $
   Total Net Income: __________________ $
   If Self Employed: Net taxable income: __________________ $
   After Tax Net income: __________________ $

6. List of Amounts Owed:
   To Whom: Amount
   __________________________ __________________________
   __________________________ __________________________
   __________________________ __________________________
   __________________________ __________________________
   Total Amount Owed: __________________________ $ __________

7. Patient has been at current address how long? __________ if less than one year, please list prior
   addresses and length of residence at each for the past year:
   __________________________ __________________________
   __________________________ __________________________
   __________________________ __________________________

8. A. Citizenship of applicant
   B. If not U.S. citizen, are you a legal resident?
   Type of visa or card __________________ Exp. Date __________
8. List of Assets:
A. Market Value of Home: $ ___________________
   Less Amt. Of Mortgage owed: $ ___________________
   Net Value $ ___________________

B. Other Real Estate Owned: $ ___________________
   Less Amt. Of Mortgage Owed: $ ___________________
   Net Value $ ___________________
   *Total Net Value $ ___________________

(*If the total is more that $50,000.00, Applicant will be asked to sign a statement promising to repay Foundation for costs of care at any such future date as the above assets are liquidated or transferred.)

C. Savings Accounts:
   Institution Where Located: ___________________
   Amount: ___________________

D. List Other Securities such as Stocks, Bonds, Cash Value of Life Insurance, etc.
   Description: ___________________
   Value: ___________________

9. Do you have Medi-Cal or Medicaid? ___________________
   Medicare? ___________________
   Medicare Supplement ___________________
   Other Insurance? ___________________
   Name of Company ___________________
   Types of Insurance ___________________
   Policy Number ___________________

10. Have you ever applied for Medi-Cal or Medicaid? ______ If yes, please describe: ___________________

I hear by authorize the Lions Eye Foundation of California - Nevada, Inc. to make any investigation concerning me and my dependents which is necessary to establish eligibility for assistance. This authorization constitutes a full and complete release from any liability resulting from disclosure of the required information. I declare under penalty of perjury under the laws of the State of California that the foregoing statement of fact provided by me is true and correct to the best of my knowledge and belief.

Signature of Patient ___________________
Or Responsible Party: ___________________ Date ___________________

Signature of Sight Conservation Chairman or other Authorized Club Representative: ___________________
Name of Club ___________________ Date ___________________

Sight Conservation Chairman
Lions Eye Foundation of California – Nevada, Inc.

To: LIONS EYE FOUNDATION OF CALIFORNIA – NEVADA, INC. Date: __________________________

From: Dr. _________________________________ Phone: _________________________________

Address: Street ______ City ______ State ______ Zip ______

Patient's Name: _________________________________ Birth date ______ Sex ______

Address: Street ______ City ______ State ______ Zip ______

Phone: _________________________________

Name of responsible Adult (parent, guardian, etc.) _________________________________

Address: Street ______ City ______ State ______ Zip ______

Phone: _________________________________

This patient is being referred for the following reason: _______________________________________

____________________________________________________________________________________

The diagnosis is: ______________________________________________________________________

____________________________________________________________________________________

Findings of complete eye exam, including visual acuity, external, slit lamp, muscles and fundus, would be most helpful.

Signed: _________________________________ M.D./O.D.

Sponsoring Lions Club

I verify that I have screened this patient with regard to the financial need and have found the patient is eligible for Foundation assistance. (Please print and sign your name to indicate you have screened the patient financially and have found him/her eligible for Foundation assistance.)

Authorized by _________________________________ Title _________________________________ Phone ______

Address: __________________________________________

Insurance Information: _________________________________

Policy Name, Numbers, etc

DO NOT WRITE BELOW THIS LINE

AUTHORIZED BY SCREENING COMMITTEE: YES ____ NO ____

Remarks: _______________________________________________________________________________

Signed: ________________________________________________

Chairman, Screening Committee, L.E.F.

HOSPITAL ADMISSION DATE: ____________________________________________________________

Instructions to Clubs: Send the original and two copies of this form to the Lions Eye Foundation, P.O. Box 7999, San Francisco, CA 94120, for approval. When approved, the patient will be contacted and given an appointment and appropriate instructions.