



ATHENS LIONS CLUB, INC.
P.O. Box 85
Athens, Georgia 30603

VISION ATHENS SIGHT SERVICES APPLICATION (FOR MINORS)

PARENT/GUARDIAN: Please return application to *above address*. Please print clearly in capital letters. Use black pen only. Keep a copy of this application.

QUALIFICATIONS

To qualify for Vision Athens vision services, client must:

- Be a Clarke County, Georgia resident for **at least one year**
- Meet income requirements
- **Submit ALL REQUIRED DOCUMENTS.** If any of the requested documents are not included with your application, we will send a letter asking for them. **This could add to the time it takes to get your glasses.**

APPROVAL PROCESS

- You will receive notice **BY MAIL** stating whether or not you qualify for vision services.
- If you qualify, the letter will give you a referral to set an appointment at an approved provider for an eye exam/glasses.

*****All Medicaid/Medicare/Peachcare recipients.** You are eligible for one eye exam per year through your insurance program. Please make an appointment with an eye doctor that accepts your insurance and **then** provide us with a **copy** of the eyeglass prescription (no older than one year) and we will help you obtain glasses. Also include a copy of your Medicaid/Medicare/Peachcare card (back and front). **If you do not include a prescription along with your application, it will be delayed. If you do not include a copy of your card, you may be denied services.**

Note: Medicaid will pay for one (1) pair of eyeglasses per year. If eye exam is current and client needs eyeglasses only please note here (include date eyeglasses were originally dispensed)

Is request for services for: Eye examination AND eyeglasses ___ or eyeglasses only___

Medicare Exception: I have Medicare but annual eye exams are not covered under my plan.
Yes _____ No _____ (Call Medicare to check whether your plan covers annual eye exams)

All questions must be completed or application will not be processed!

REQUIRED DOCUMENTS

Make sure the following are COMPLETED and ENCLOSED before mailing. Send COPIES, not originals.

- .. Completed application
- .. Current eyeglass prescription (less than 1 year old) if you have already received an exam.
- .. Required documents: ONE form of identification for parent/guardian and ONE for client (school ID card or other), ONE proof of residency, and THREE proofs of income of parent/guardian.
- .. Medicaid/Medicare/Peachcare recipients MUST include a copy of their card(back and front)

If any of these documents are not included, we will send a letter asking for them. This could add to the time it takes to get your appointment.

<i>Choose ONE form of ID and ONE proof of residency</i>	<i>Send THREE documents which apply for you or anyone living at your address</i>	
IDENTIFICATION	PROOF OF RESIDENCY	PROOF OF INCOME
GA Driver's License Georgia Identification card GA Birth Certificate Voter's Registration Card	Copy of first page of your lease (rental) agreement Mortgage statement Letter from home, shelter, or transitional home stating that you live at that location (on letterhead and signed by home/shelter employee). Something that comes through the mail, in your name, to your address.(ex: utility bill, bank statement, Social Security letter, library card)	Last year's tax return Last 3 months of bank statements 3 current pay check stubs Social Security Administration Award Letter. (If you receive direct deposit, circle the item on the bank statement) Food Stamp papers from DFACS (award summary) Letter from nursing home stating amount received for personal expenses Unemployment Claim/Wage Inquiry statement Information, including monthly amount received, of any other sources of income (ex: TANF, pension, retirement, child support)

Circle services needed: Eye Exam _____ Eyeglasses _____ Both _____

Is this application for someone under 18 years old? Yes _____ No _____

Has applicant been diagnosed with diabetes? Yes _____ No _____

Has applicant been diagnosed with glaucoma? Yes _____ No _____

Please answer ALL questions. Print clearly in CAPITAL LETTERS with a black pen.

1. Applicant's Name:

Title First Middle Last Suffix

2. Name of Parent/Guardian (if applicant is a child):

Title First Middle Last Suffix

3. Address: _____

4. City: _____ 5. State:: _____

6. Zip Code: _____ 7. County: _____ 8. Sex: **M** **F**

9. Last 4 digits of applicant Social Security Number: _____

10. Date of Birth ____/____/____

11. Home Phone: _____ 12. Cell Phone: _____

13. Work Phone: _____

14. Email Address: _____

15. Are you employed?: **Y** _____ **N** _____

16. If no, are you actively seeking employment? **Y** _____ **N** _____

17. If you are unemployed, why? Circle all that apply:

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

18. How long have you been a legal Georgia resident? _____ **Years**

19. Race: **White** **African American** **Hispanic** **Asian** **Other**

20. Insurance: Please circle every type of insurance you have.

Medicare** **Medicaid**** **VA** **PeachCare**** **Other** **None**

***Please include a current eyeglass prescription (less than 1 year old)*

21. Marital Status: **Married** **Single** **Divorced** **Separated** **Widowed**

Does client wear eyeglasses now? _____ If yes, for how many years _____
Wear contact lenses? _____ (Note: Vision Athens does not pay for contact lenses except in approved circumstances for a medical condition)
Date of last eye examination _____
Has a Lions Club purchased glasses for you or anyone in your family? Y _____ N _____
If yes, please list name(s) of recipients & date received

How did you become aware of Vision Athens/Lions Club/Lighthouse sight services?

Financial Information (Must be completed with valid income proof supplied)

Your Employer _____
Annual Income _____
Spouse's Employer _____
Annual Income _____

Monthly Income & Benefits

Social Security \$ _____ SSI \$ _____
Pensions \$ _____
Child Support \$ _____
Unemployment \$ _____ Other \$ _____

List everyone, including yourself, living at your address. (Please attach additional household members on separate sheet)

Name: _____ **Dependent?** Y _____ N _____

Relationship: _____ **Age:** _____

Amount of Monthly Income: \$ _____

Name: _____ **Dependent?** Y _____ N _____

Relationship: _____ **Age:** _____

Amount of Monthly Income: \$ _____

Name: _____ **Dependent?** Y _____ N _____

Relationship: _____ **Age:** _____

Amount of Monthly Income: \$ _____

TOTAL NUMBER OF DEPENDENTS: _____

Total Number of People in Household: _____
(Combined income of all people living at your address)

Total Monthly Household Income: \$ _____

Please Read and Sign This Statement:

"I fully understand Vision Athens 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 Vision Athens will not pay for any eyeglasses billed to me prior to approval of this application. I also understand my application may be reviewed by the Athens 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

If you want us to be able to speak with a friend or family member, please complete all information. If you want us to speak only with you, do not check the box to the right. **EVERYONE MUST SIGN AND DATE THIS PAGE.**

1. Name _____
2. Relationship to Applicant: _____
3. Emergency Phone: _____
4. Address: _____
5. City _____ 6. State _____ 7. Zip Code _____

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 how long you give us permission to speak with your friend or family member.**

___ one (1) year

___ specified expiration date: _____ / _____ / _____

___ or 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 (with title of relationship) **Date**

Signature of Authorized Representative
(Person chosen by the applicant to speak with the Lighthouse) Date

Steve Helwig, Program Coordinator
Athens Lions Club
lion.swampthing@gmail.com
C: 706-340-2018

For Vision Athens use only:

Date application received _____

Eye examination only _____ Glasses only _____ Both _____

Date reviewed by Vision Athens committee _____

Date approved/denied/additional information requested _____

Approved-date referred to provider/voucher sent _____

Denied-date letter sent to applicant _____

Additional information requested: Date request sent _____

Information requested _____

Provider name _____

Date services provided _____

Eyeglasses-date form sent to Lighthouse _____

Date returned to provider _____

Date paid by Vision Athens _____

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