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:

Dependents: Name, Age, Relationship
1. _____
2. _____

Dependents: Name, Age, Relationship
3. _____
4. _____

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