

LIONS EYE BANK OF DISTRICT 2-T1, INC.
APPLICATION FOR PAYMENT TOWARD SIGHT SAVING SURGERY

AUTHORIZATION OF AND PAYMENT ON CASES:

ALL applications for financial assistance from the Lions Eye Bank of District 2-T1, Inc., **MUST** be sponsored by a local Lions Club located on Lions District 2-T1. The sponsoring of a case is **NOT** a responsibility to be taken lightly; nor is the task of insurmountable proportions. It is the responsibility of the sponsoring club to personally interview the applicant or the applicant's family in order to acquaint themselves with the case and to complete and return **ALL** necessary forms, along with a recommendation to the Eye Bank Board so that they may issue authorization for financial assistance. These forms **MUST** be received at the Eye Bank office at a date **PRIOR** to the date of surgery as the Board **CANNOT** authorize funds for surgery already performed. **EMERGENCY** cases are limited to accidental injuries or those conditions requiring immediate surgery. In the event emergency authorization is required, your club can contact the Eye Bank President, Vice President or Treasure to begin an expedited authorization process. A written application **MUST** then be submitted **PROMPTLY** for final authorization.

Upon receipt of a completed application, the Board will review the case to determine the financial eligibility of the applicant. If the applicant is found to be within the eligibility requirements, the Board will proceed to issue written authorization which will be necessary **BEFORE** we are able to process any statements received pertaining to that case. If the case is denied, the Board will contact the sponsoring Lions Club and inform them of this fact.

PROCEDURE FOR AUTHORIZATION:

The following forms are provided to the local Lions Clubs for the submission of information which is necessary for the Board to authorize a case:

FORM 1 ~ Instruction Sheet ~ This sheet contains ALL necessary information to complete the application. It is important for the sponsoring Lions Club to read this information carefully and to follow the instructions closely.

FORM 2 ~ Application for Sight Saving Surgery and Hospitalization Assistance ~ This form is to be completed by the sponsoring Lions Club at their interview with the applicant or applicants family. It should be noted that ALL forms are to be legibly completed, and that ALL information required is given. After supplying this information, the local Lions Club certifies the information as being correct to the best of their knowledge by supplying a letter of recommendation for the applicant (**FORM 3 ~ Letter of Recommendation By Local Lions Club**), and by signing the form.

FORM 3 ~ Letter of Recommendation By Local Lions Club ~ The local Lions Club certifies the interview information as being correct to the best of their knowledge and recommends the applicant for financial assistance from the Lions Eye Bank of District 2-T1, Inc.

FORM 4 ~ Certification of Surgical Providers ~ This form is to be completed by those who will be providing services during the applicant's eye surgery. Again, ALL information required should be supplied and the form signed by the attending Ophthalmologist, or a person of authority at the facility where the surgery will be performed. Fees stated on this form should be in accordance with our fee schedule which is printed on the back of the form. This is our assurance that ALL providing services during the applicant's surgery are willing to cooperate with our effort to assist those less fortunate.

FORM 5 ~ Applicant's Permission for Surgery and Hospitalization and Certification of U.S. Residence ~ This form is our legal protection and is to be completed by the applicant or applicant's family, and witnessed by the Local Lions Club member completing the interview.

IMPORTANT ~ PLEASE NOTE: BEFORE FORWARDING THE FORMS TO THE BOARD, THE SPONSORING LIONS CLUB SHOULD REVIEW THE FORMS TO ASCERTAIN THAT **ALL** NECESSARY INFORMATION IS PROVIDED, THAT **ALL** NECESSARY SIGNATURES ARE ON THE FORMS AND THE FEES LISTED ARE WITHIN THAT WHICH WE ALLOW FOR THE SURGERY PERFORMED. IF THE NECESSARY INFORMATION OR SIGNATURES ARE **NOT** SUPPLIED, AND/OR THOSE PROVIDING SERVICES HAVE **NOT** COMPLETED THE REQUIRED FORMS, OR HAVE LISTED A FEE IN EXCESS OF THAT WHICH IS SHOWN ON OUR FEE SCHEDULE, WE WILL HAVE TO RETURN THE COMPLETE APPLICATION RESULTING IN UNNECESSARY DELAY. **THE LIONS EYE BANK OF DISTRICT 2-T1, INC. CAN NOT ASSUME ANY FINANCIAL RESPONSIBILITY FOR TREATMENT GIVEN WITHOUT WRITTEN AUTHORIZATION.**

FORM 6 ~ Official LIONS EYE BANK OF DISTRICT 2-T1, INC. Authorization ~ This form is issued to the sponsoring Lions Club when and if the applicant is found to be eligible for the Boards assistance. This form indicates the amounts authorized for the various expenses associated with the surgery to be performed. One copy of the original authorization form is to be retained by the sponsoring Lions Club with copies being distributed to the doctor, anesthesiologist and to the hospital upon admission. This form reiterates that the applicant is **NOT** to be billed for amounts in excess of our authorization. insurance proceeds should be deducted from the Board's allowance **PRIOR** to billing the Lions Eye Bank of District 2-T1, Inc.

It is very important that the sponsoring Lions Club read and familiarize themselves with these forms so that **ALL** necessary information is submitted and that **ALL** instructions are followed. The sponsoring Lions Club acts as a representative of the Lions Eye Bank of District 2-T1, Inc. **AND** is expected to be of assistance in the handling of the case as it becomes necessary. This may involve providing information or assistance to the applicant and occasionally contacting the doctor or hospital to gather the information or to explain the purpose and policies of the Eye Bank. It has been our experience that most physicians and hospitals will cooperate with the Lions Eye Bank, once they are made aware that we are a charitable organization supported solely by contributions from the Lions of District 2-T1 and from the operation of the local eye bank.

Upon receipt of statements from doctors and hospitals for authorized cases, the Board will process these statements promptly and remit our payments to the extent of our authorized amount for that case. In the event **ANY** correspondence regarding the case is necessary, the sponsoring Lions Club will receive a copy of **ALL** letters written, as well as copies of **ANY** pertinent supporting information, so that they may be informed of **ANY** developments pertaining to the case.

INSTRUCTION SHEET

IMPORTANT ~ READ CAREFULLY and PLEASE FOLLOW INSTRUCTIONS

DO NOT PROCEED with surgery or hospitalization **BEFORE** receiving **FORM 6 ~ Official LIONS EYE BANK OF DISTRICT 2-T1, INC. Authorization** signed by an authorized OFFICER, or in

EMERGENCY CASES ~ IMPORTANT: Telephone the Lions Eye Bank of District 2-T1, Inc. or its President for authorization for surgery and hospitalization.

QUALIFICATIONS

The applicant (if a minor, parent or guardian) **MUST** be unable to pay for surgery and hospitalization and **MUST** come within the scope of our financial eligibility requirements and restrictions

PROCEDURE

1. Every applicant **MUST** be sponsored by a local Lions Club. **FORM 2 ~ Application for Sight Saving Surgery and Hospitalization Assistance** is to be completed by a Lions Club member after interviewing the applicant or applicant's family, thus establishing financial eligibility and personal contact. **FORM 4 ~ Certification of Surgical Providers** is to be completed by the attending ophthalmologist, stating type of surgery, date and fee, as per our schedule. The facility where the surgery will be performed, in addition to the anesthetist, are also to sign the form indicating their willingness to participate with our charitable program. **FORM 5 ~ Applicant's Permission for Surgery and Hospitalization and Certification of U.S. Residence** is our legal protection and certification of residence, which **MUST** be dated, signed and witnessed **BEFORE** surgery.
2. **PLEASE** be sure nothing is left blank. A blank information area on the forms indicates the form is **NOT** completed. Draw a line or write "none" where applicable. Forms containing unanswered questions, or the absence of a written denial letter from a tax supported agency, **WILL** result in the return of the application thus resulting in a delay of approval.
3. **PLEASE** advise regarding Medicare - one or both plans. The Eye Bank **WILL** pay that part of surgery and hospitalization expenses **NOT** covered by Medicare, provided each bill is **NOT** in excess of our stated fee schedule. Medicare will pay 80% of the cost of post-surgical glasses. The Eye Bank **WILL** pay the balance.
4. When **ALL** forms are completed, **MAIL** to the Eye Bank. If **ALL** forms are in order and the case is approved, the official authorization **WILL** be sent to the sponsoring Lions Club (unless requested by them to be sent elsewhere). This **WILL** authorize the amount of money allowed for surgery, hospitalization, anesthesia and glasses. One copy of **FORM 6 ~ Official LIONS EYE BANK OF DISTRICT 2-T1, INC. Authorization** is to be presented to the surgeon, one to the hospital, and one to the anesthesiologist. A remaining copy is for the information of the sponsoring Lions Club. Copies of **ALL** correspondence pertaining to a case, **WILL** also be forwarded to the Lions Club for their information **ONLY**, unless otherwise specified. Should a problem arise concerning statements, the sponsoring Lions Club may be requested to intervene on our behalf. If the application is rejected, the sponsoring Lions Club **WILL** be notified.

RESTRICTIONS

1. Glasses ~ Allowed **ONLY** as part of the authorized surgery.
2. The Eye Bank will **NOT** accept applications or pay for **ANY** illness other than that pertaining to diseases or injury to the eye.
3. Applicant being unable to pay, is **NOT** to be charged for surgical or hospital expenses.
4. Patient **MUST** have **LEGALLY** resided in the U.S.A. for a period of **NOT** less than 1 year.
5. **Each patient MUST have applied to and been denied funding from a tax supported agency (i.e.: TEXAS DEPARTMENT OF ASSISTIVE and REHABILITATIVE SERVICE 800-687-7010). Written denial MUST accompany this application.**

SELECTION OF DOCTOR

The applicant (parent of guardian if a minor) is to select the doctor.

CROSS EYES

(Esotropia, Strabismus, Squint, or Muscle Surgery) in children 16 and under **WILL** be approved if applicant (parent or guardian) qualifies.

NO BILL WILL BE PAID UNTIL FORM 6 ~ Official LIONS EYE BANK OF DISTRICT 2-T1, INC. Authorization IS ISSUED, BEARING AN AUTHORIZED SIGNATURE OF AN OFFICER OF THE LIONS EYE BANK OF DISTRICT 2-T1, INC.

FORM 2—APPLICANT TO COMPLETE

Page 2 of 3

APPLICATION FOR SIGHT SAVING SURGERY AND HOSPITALIZATION ASSISTANCE

NOTE: PLEASE, ALL QUESTIONS MUST BE ANSWERED.

NOTE: APPLICANT MUST BE INTERVIEWED BY A MEMBER OF A LOCAL LIONS CLUB.

AND FORM 2 ~ Application for Sight Saving Surgery and Hospitalization Assistance CERTIFIED BY HIM / HER

FORM 2

Please answer EVERY QUESTION: (If it does NOT apply, mark "no" or "none") otherwise forms WILL be returned, thus causing delay. If applicant is a minor or is living with and or supported by parents, data required pertains to both the parent(s) or guardian(s) and applicant.

12. Name of applicant _____

13. Age _____

14. If minor, name of parent(s) or guardian(s) _____

15. Name of Employer _____

16. Dates of employment; from _____ to _____

17. Own business? _____ Net Worth \$ _____ Kind _____ Wages _____ Draws _____

18. If no income, how are you supported? _____

*19. Have you been accepted for assistance for eye surgery and or hospitalization from Welfare, Aid to Blind, Medical Aid to Aged, etc.? _____

If yes, give name(s) of company/companies or agency/agencies _____

*20. If no, explain circumstances and submit copy of agency's statement of rejection. _____

* Please note that if questions #19 & 20 are not answered and written documentation is NOT provided, this application will be returned.

21. Can any member of family contribute toward Surgery of Hospitalization? _____ To what extent? _____

22. Do you carry Blue Cross, Blue Shield, or ANY other medical or hospitalization insurance? Give name of insurance company or companies: _____

23. Are the agencies listed in lines #19 & 22 (if any) expected to pay in excess of our allowances? _____ (See Fee Schedule of Form No 3)

24. Are you registered with the Medicare/Medicaid Programs to cover doctor's fees? YES _____ NO _____

or Hospital fees? YES _____ NO _____.

INCOME RECEIVED ANNUALLY

25. Salary of Husband ~ Net \$ _____

26. Salary of Wife \$ _____

27. Salary of Parent(s) Guardian(s) \$ _____

28. Social Security \$ _____

29. Old Age Assistance \$ _____

30. Unemployment Insurance \$ _____

31. Disability Pension \$ _____

32. Retirement Pension \$ _____

33. Welfare Assistance \$ _____

34. Additional Income/other family members \$ _____

35. Rent from **ANY** Property/Roomer/Boarder \$ _____

36. Investments \$ _____

37. Other income \$ _____

38. **TOTAL NET INCOME (Annually)** \$ _____

39. Number of Family dependent on income above _____

ASSETS

Real Estate _____

40. Present Market Value \$ _____

41. Less Mortgages or Other Loans \$ _____

42. Applicant's Equity in Real Estate \$ _____

43. Bank Account/ Savings/CDs \$ _____

44. Bank Account/Checking \$ _____

45. Insurance--CASH VALUE \$ _____

46. Stocks/Bonds: Market Value \$ _____

47. Other Assets \$ _____

LIST ANY UNUSUAL or EXTENUATING CIRCUMSTANCES _____

48. **TOTAL NET ASSETS** \$ _____

APPLICATION FOR SIGHT SAVING SURGERY AND HOSPITALIZATION ASSISTANCE

SUGGESTIONS FOR LOCAL LIONS CLUBS

FOLLOWING IS THE UPDATED SUGGESTIONS FOR FINANCIAL ELIGIBILITY AUTHORIZED BY THE LIONS EYE BANK OF DISTRICT 2-T1, INC.

UPDATED MARCH, 2007

1. FINANCIAL ELIGIBILITY REQUIREMENTS:

A. ALLOWABLE ANNUAL NET INCOME:

ONE IN FAMILY	\$18,169.27
TWO IN FAMILY	\$20,591.84
THREE IN FAMILY	\$23,014.14
FOUR IN FAMILY	\$25,435.97
FIVE IN FAMILY	\$27,859.54
SIX IN FAMILY	\$30,282.11

B. TOTAL ASSETS OF APPLICANT SHOULD NOT EXCEED \$60,564.23.

ASSETS MADE UP OF EQUITY IN HOME, BANK ACCOUNTS AND OTHER ASSETS.
PLEASE NOTE THAT A VEHICLE IS NOT CONSIDERED AN ASSET.

C. INDICATE ANY EXTENUATING CIRCUMSTANCES WHICH YOU MAY DEEM NECESSARY IN DETERMINING THE ELIGIBILITY OF THE APPLICANT.

2. CONTACTING DOCTORS, HOSPITALS, AND ANESTHETISTS:

PERSONAL CONTACT WITH THE DOCTORS, HOSPITALS AND ANESTHETISTS MAY BE HELPFUL IF THOSE PERSONS AND/OR INSTITUTIONS HAVE NOT PREVIOUSLY SOUGHT FUNDING FOR THEIR PATIENTS THROUGH THE EYE BANK. THEY SHOULD KNOW THE ALLOWABLE AMOUNTS OF FEES AND THAT THE PATIENTS HAVE NO FURTHER LIABILITY OR RESPONSIBILITY FOR PAYMENT. (THIS APPEARS ON FORM #3 SIGNED BY THEM). THESE ALLOWABLE FEES ARE REVIEWED ANNUALLY BY THE BOARD OF DIRECTORS AND ARE REVISED PERIODICALLY, BUT ARE GENERALLY NOT THE NORMAL FEES CHARGED. MOST DOCTORS AND HOSPITALS WILL ACCEPT THESE FEES, IF IT IS EXPLAINED THAT WE ARE A CHARITABLE ORGANIZATION.

3. **Each patient MUST have applied to and been denied funding from a tax supported agency (i.e.: TEXAS DEPARTMENT OS ASSISTIVE and REHABILITATIVE SERVICE 800-687-7010).
Written denial MUST accompany this application.**

Recommendation of Local Lions Club

1. How long and under what circumstances have you known the applicant or family?

2. Remarks or recommendations:

I certify as a Lions Club member, to the best of my knowledge and through personal interview with the applicant, the above information is correct and I recommend the applicant.

(Signature)

Address: _____, City _____ State _____, Zip _____.

I am a member in good standing of the _____ located in _____.
(Lions Club) (City, State)

CERTIFICATE OF SURGICAL PROVIDERS

**DO NOT PERFORM SURGERY UNTIL AUTHORIZATION FORM #5 IS RECEIVED
OR
AUTHORIZATION IS GIVEN BY TELEPHONE DIRECTLY FROM THE PRESIDENT OR VICE PRESIDENT OF
THE
LIONS EYE BANK OF DISTRICT 2-T1, INC.
OTHERWISE,
THE LIONS EYE BANK OF DISTRICT 2-T1, INC. IS NOT RESPONSIBLE FOR ANY EXPENDITURES.**

IF ANY PART OF SURGERY OR HOSPITALIZATION IS ASSUMED BY WELFARE, UNIONS, INSURANCE OR MEDICARE/MEDICAID, SAME SHOULD BE DEDUCTED FROM AMOUNT AUTHORIZED BEFORE BEING PRESENTED FOR PAYMENT. ATTENDING OPHTHALMOLOGIST IS TO COMPLETE PART A; HOSPITAL OR FACILITY IS TO COMPLETE PART B; ANESTHETIST IS TO COMPLETE PART C. PLEASE ANSWER EVERY QUESTION, OTHERWISE FORMS WILL BE RETURNED, THUS CAUSING A DELAY.

PART A

Date: ____/____/____

Patient's Name: _____ Sex: _____ Age: _____

Address: _____ City: _____ State: _____ Zip: _____

Has the patient any incurable malady such as Diabetes, etc., affecting the eyes? YES _____ NO _____ (Check One).

1. DIAGNOSIS: _____

2. TYPE OF SURGERY RECOMMENDED: _____

3. APPROXIMATE DATE RECOMMENDED FOR SURGERY: ____/____/____.

4. PREVIOUS TREATMENT FOR THIS CONDITION: _____

5. Doctor's fee, including examinations, surgery, post-operative care and refraction, as per our schedule on page 3 of this form.

Doctor's Office Phone Number: (____) _____ - _____. Doctor's Fax Number (____) _____ - _____.

Doctor's fee to be waived to research? YES _____ NO _____ (Check One).

Doctor's Name: _____, M. D.

Address: _____ City: _____ State: _____ Zip: _____

6. RIGHT EYE: _____ LEFT EYE: _____ OR BOTH EYES: _____ NUMBER OF HOSPITAL DAYS: _____

7. GLASSES: _____ OR CONTACT LENSES: _____

8. IS PATIENT COVERED BY MEDICARE? YES _____ NO _____ (Check One). PLAN A _____ or PLAN B _____

9. ARE OTHER SOURCES OF AID AVAILABLE? YES _____ NO _____ (Check One). IF SO, PLEASE DESCRIBE:

I HEREBY AGREE TO ACCEPT AUTHORIZATION AS PAYMENT IN FULL.

DOCTOR'S SIGNATURE: _____ M.D.

Date: ____/____/____

CERTIFICATE OF SURGICAL PROVIDERS

PART B

10. FACILITY'S FEE, AS PER OUR SCHEDULE ON PAGE 3 OF THE FORM.

NAME: _____

ADDRESS: _____ City: _____ State: _____ Zip: _____

**THIS INSTITUTION DOES HEREBY AGREE TO ACCEPT AUTHORIZATION AS
PAYMENT IN FULL.**

SIGNATURE: _____ Title: _____ Date: ____/____/____

PART C

11. ANESTHETIST'S FEE, AS PER OUR SCHEDULE ON PAGE 3 OF THE FORM.

NAME: _____

ADDRESS: _____ City: _____ State: _____ Zip: _____

I HEREBY AGREE TO ACCEPT AUTHORIZATION AS PAYMENT IN FULL.

SIGNATURE: _____ Title: _____ Date: ____/____/____

APPLICANT IS NOT TO BE CHARGED FEE IN EXCESS OF AMOUNT AUTHORIZED.

**CERTIFICATE OF SURGICAL PROVIDERS
FEE SCHEDULE**

FOLLOWING IS A SCHEDULE OF SURGICAL AND HOSPITAL FEES AS PRESENTLY AUTHORIZED BY THE LIONS EYE BANK OF DISTRICT 2-T1, INC.

UPDATED: 02/2007

<u>PROCEDURE</u>	<u>SURGEON</u>	<u>FACILITY</u>	<u>ANESTHESIA</u>	<u>MISC. OPT.</u>
All per eye unless otherwise stated)				
Cataract *, **	\$ 755	\$ 825	\$ 275	\$ 140 (Glasses)
Intra-ocular lens				\$ 220
Yag	\$ 250	\$ 250		
Sclera Buckle *, **	\$ 880	\$ 1050	\$ 360	
Trabeculectomy *, **	\$ 550	\$ 825	\$ 220	
With Ahmend Valve				\$ 1,350
Virectomy *, **	\$ 825	\$ 825	\$ 220	
Corneal Transplant *, **	\$ 880	\$ 825	\$ 360	\$ 1,000 (Tissue Handling)
Enucleation *, **	\$ 700	\$ 825	\$ 220	\$ 605 (For Prosthesis)
Strabismus (One or OU) ^	\$ 550	\$ 550	\$ 220	
Exam With Anesthesia ^^	\$ 110	\$ 305	\$ 140	
Blow-Out Fracture *, ^	\$ 700	\$ 825	\$ 220	
Ptosis **	\$ 550	\$ 825	\$ 220	
Foreign Body	\$ 385	\$825	\$ 220	
Argon Laser ^^	\$ 235	\$ 195		
(Includes angiogram. Limitations: Two Laser Treatments Per Eye				
Pterygium With Graph	\$ 700	\$ 1,100	\$ 220	
Contact Lens				\$ 85 Per Lens

LEGEND:

* \$ 1155 (Twenty-Three Hour Observation Fee May Apply)

** \$ 825 Outpatient May Apply

^ \$ 550 Outpatient May Apply

^^ \$ 305 Outpatient May Apply

In Medicare cases, we will pay the part of the surgery and hospitalization expenses NOT covered by Medicare, provided the total received by each provider is NOT in excess of our stated fee schedule.

Our program is NOT set up to allow for any services provided by doctors other than the attending ophthalmologist or optometrist. If the services of other physicians are essential, the surgeon should so note on his statement and charge ONLY an appropriate percent of our allowance for surgery so that a sufficient balance will remain to cover these charges.

Our allowance for glasses, contacts, intra-ocular lens and prosthesis is to cover the initial optical requirement following an authorized surgical procedure; however, our program does NOT provide for subsequent replacements.

All allowances for doctor's fees include charges incurred from examination, surgery, post-op care and refractions.

Please make every effort to use lenses or those discounted for charity cases.

Each patient MUST have applied to and been denied funding from a tax supported agency (i.e.: TEXAS DEPARTMENT of ASSISTIVE and REHABILITATIVE SERVICE 800-687-7010).

Written denial MUST accompany this application.

APPLICANT'S PERMISSION FOR SURGERY, HOSPITALIZATION AND CERTIFICATION OF RESIDENCE

PRINT or TYPE

DATE PRIOR TO SURGERY

Date:

I hereby authorize Doctor _____

Address _____, City _____, State _____, Zip _____

the surgeon who has been selected by me (parent or guardian of applicant if a minor) to perform surgery pertaining to diseases or injuries of the eye only, which he / she may recommend, authorize and prescribe, including the administering of anesthesia, the designation of the hospital, hospitalization therein, and postoperative care and / or any subsequent surgery or hospitalization pertaining thereto, to be performed on

_____, myself (or minor).
(Name of Applicant)

I hereby absolve the Lions Eye Bank of District 2-T1, Inc., of any responsibility in connection with the surgery, hospitalization or postoperative care of myself (or minor).

If I am to receive assistance, I understand the cost thereof as may be authorized by the Lions Eye Bank of District 2-T1, Inc., will be financed by them, as indicated on Authorization Form Number 5 bearing authorized signature. I agree any funds I receive from insurance, etc. is to be applied toward payment of bills. Not other illness will be covered by the Authorization.

I understand that no surgery is to be performed until I have signed this form Number 4 and I have received Authorization Form Number 5, or authority has been given by wire or phone directly from the Eye Bank Board. I understand that the Lions Eye Bank of District 2-T1, Inc., will NOT be responsible for any expenses if these instructions are NOT followed.

I certify I have been a legal resident of the United States of America for a period of NOT less than one (1) years.

Signature of Applicant (or parent of guardian if a minor)

WITNESS:

Name: _____

Address: _____

City: _____, State: _____, Zip: _____

Phone Number: (_____) _____ - _____

OFFICIAL AUTHORIZATION

The Board of Directors of the Lions Eye Bank of District 2-T1, Inc., has authorized a reimbursement / payment for sight saving eye surgery for

_____ of _____ recommended
(Name of Applicant) (City, State)

by the _____ of _____.
(Local Lions Club) (City , State)

Such reimbursement or direct payment to the doctors / hospital is authorized in an amount NOT to exceed
\$ _____.

Once the surgery has been completed, a copy of the physicians / hospital charges will be forwarded to the Lions Club Eye Bank of District 2-T1, Inc. Prior to the funds being disbursed.

After a brief review of these charges by the Board, the authorized funds will be forwarded to the appropriate party.

LIONS EYE BANK OF DISTRICT 2-T1, INC.

BY: _____
(President / Vice President / Treasurer)

WITNESSED BY:

(Board Secretary)