



The Georgia Lions Lighthouse is a 501(c)3 nonprofit. Our mission is to provide vision and hearing services through education, detection, prevention, and treatment. The services we provide are made possible by donations and support from individuals, foundations, and the business community.

Vision Services Application Overview

Please **check** the box for the services that you are applying for:

- Eye Exam and Eyeglasses
- Eyeglasses only

QUALIFICATIONS

To qualify for Lighthouse program services, you must:

- Be a Georgia resident
- Meet our income requirements
- **Submit copies of ALL required documents.** If any of the documents are not included with your application, your request will not move forward

APPROVAL PROCESS

- You will receive notice **by mail within 4 weeks** stating whether or not you are qualified to receive our services. (if address changes please contact our office to notify our staff)

Once completed, send your application and copies of all required documents to us by mail, fax, or email. If you have any questions, please call us at 404.325.3630.

Mail

Georgia Lions
Lighthouse
Foundation
5582 Peachtree Road
Chamblee, GA 30341

Fax

404-636-5549

Email

visionapp@lionslighthouse.org



Application Check-List

The following MUST be submitted for this application to be considered

Failure to include these documents **will** delay your application process. Patients are responsible for providing copies of the required documents listed below.

Required Documents

- Photo ID: GA driver's license ***or*** DMV issued photo ID ***or*** passport or GA consulate ID card ***or*** permanent residence card
- Proof of Income: 3 recent pay stubs ***or*** recent tax return ***or*** Social Security Award Letter ***or*** letter from IRS proving that you do not file taxes (form 4506-T)
- Medicare/Medicaid card ***or*** Grady card ***or*** Peachtree card ***or*** private insurance card
- If you are seeking assistance for eyeglasses only, please attach a copy of your current vision prescription (***cannot be more than 2 years old***)***

*****All Medicaid/Medicare/Grady Card/Peachcare/Private Insurance 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 prescription (*cannot be more than 2 years old*) and we will help you obtain glasses. If you do not include a prescription along with your application, it will be delayed.



Last Name: _____ First Name: _____ MI: _____

Address: _____

City: _____ State: Georgia Zip Code: _____

County of Residence: _____

Home Phone: _____ Mobile Phone: _____

Name of Parent or Guardian (if under 18): _____

Referred by: _____ Primary Care Provider: _____

Date of Birth: ____/____/____ Gender: Male Female

Marital Status: Single Married Divorced Separated Widowed

Last four digits of Social Security Number: _____

Are you employed? Y N If no, are you seeking employment? Y N

If you are unemployed, please provide the reason:

Disabled (circle if you receive SSI/SSDI) Not Able Retired Lost Job Other

Email Address: _____

Race: White African American Hispanic Asian Other

Primary language: _____

Are you a veteran? Y N

Are you a student? Y N

Please circle the type of insurance coverage you have.

Medicaid Medicare VA PeachCare Grady Card Other None

Total number of dependents: _____ Total Monthly Household Income: \$ _____

Total Number of People in Household: _____

(OVER)

REQUIRED

Lighthouse Statement

Please read and sign.

"I fully understand Lighthouse services are limited to Georgia 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 the services rendered. I am aware that the Lighthouse will not pay for any eyeglasses billed to me prior to approval of this application. I also understand that my application will be reviewed by a Lighthouse Provider, 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

REQUIRED

HIPPA Agreement

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 one year.



Signature of Applicant (person applying for services) Date

OPTIONAL

Additional Contact Information

Complete this portion only if you would like to give us permission to speak with someone else on your behalf regarding your services.

Name _____ **Relationship to Applicant:** _____

Phone number: _____

Signature of Applicant (person applying for services) Date

Signature of Authorized Representative Date

(Person chosen by the applicant to speak with the Lighthouse)



**Georgia Lions
Lighthouse Foundation**
Better Vision. Better Hearing. Better Georgia.

Submitting Your Application

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