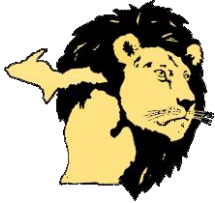


LIONS OF MICHIGAN FOUNDATION



5730 Executive Drive, Lansing, MI 48911
(Voice) 517-887-6640 (Fax) 517-887-6642
(Email) info@lmsf.net

APPLICATION #	
DATE REC'D	
REVIEW PERIOD	
DETERMINATION	
FOR OFFICE USE ONLY	

INDIVIDUAL ASSISTANCE APPLICATION

1. SPONSOR – Lions Club or Lions District

Name:	
Contact Person:	
Address:	
City/State/Zip:	
Daytime Telephone:	
Email:	

2. APPLICANT

Name:	
Address:	
City/State/Zip:	
Daytime Telephone:	
Date of Birth:	
Social Security Number:	

3. APPLICANT'S PARENT/LEGAL GUARDIAN: *(For Applicants Under Age 18)*

Name:	
Daytime Telephone:	

4. IS THE APPLICANT A UNITED STATES CITIZEN? YES NO

5. REASON FOR REQUEST: DIAGNOSIS & RECOMMENDED TREATMENT

A letter from the applicant's care or service provider stating the need for treatment, urgency, and estimated cost must be attached to the application. All medical equipment and devices must be recommended by a licensed medical practitioner.

6. APPLICANT'S SERVICE OR CARE PROVIDER:

Name:	
Telephone Number:	
Email:	

7. APPLICANT'S INSURANCE *(Please Check One)*

NONE MEDICAID MEDICARE PRIVATE INSURANCE

Type/Provider:	
Policy & Group Number:	
Coverage Limitations:	

8a. THE LIONS OF MICHIGAN FOUNDATION provides financial assistance based on the Medicare Allowable Rate for recommended medical procedures and medical equipment/devices. Did the service provider(s) or supplier(s) agree to accept the Medicare Allowable Rate or a lower fee for the applicant?

b. TOTAL COST of recommended procedure, equipment or device: \$ _____

c. FUNDING REQUIRED from the Lions of Michigan Foundation: \$ _____

d. HOW HAS THE APPLICANT been helped by area Lions Clubs and other community service organizations? Were special fundraisers held? What was the total amount collected for the applicant?

9. APPLICANT'S MUST CONTACT all applicable state and federal government agencies for possible assistance.

	Agency	Contact Person	Phone #	Result of Inquiry
a.	Michigan Department of Human Services: (517 373-2035)			
b.	Social Security Administration: (800 772-1213)			
c.	United States Department of Veterans Affairs: (800 827-1000)			

10. APPLICANT'S SHOULD CONTACT all area hospitals to inquire about free or reduced fee care for the low income and uninsured. Non-profit hospitals are obligated to provide a certain level of free or reduced fee services to retain their non-profit status. Many hospitals operate their own foundation to assist uninsured and underinsured individuals in the communities where they provide services.

Hospital: _____

Result of Inquiry: _____

11. HOUSEHOLD MEMBERS EXCLUDING APPLICANT:

Name	Relationship to Applicant	Age

12. HOUSEHOLD INCOME: (Attach Federal Form 1040, 1040A or 1040EZ)

INCOME	AMOUNT/Monthly	AMOUNT/Yearly
Wages, Salary and Tips (Attach W-2 Forms)		
Unemployment Compensation		
Social Security Benefits		
Food Assistance Program Benefits		
Family Independence Program Benefits		
Veterans Benefits		
Alimony and Child Support Received		
Interest and Dividend Income		
Business Income/Loss		
Pensions, Annuities & IRA Distributions		
Farm Income/Loss		
Other Income (Attach Schedule)		
TOTAL HOUSEHOLD INCOME:		

13. DEDUCTIONS FROM INCOME:

DEDUCTIONS	AMOUNT
Health Savings Account Deduction (Form 1040, Line 25)	
½ Self Employment Tax (Form 1040, Line 27)	
Self Employed Health Insurance Deduction (Form 1040, Line 29)	
Tuition & Fees Deduction (Form 1040, Line 34)	
Penalty -Early Withdrawal of Savings (Form 1040, Line 30)	
Other Deductions (Attach Schedule)	
TOTAL INCOME DEDUCTIONS:	

FOR OFFICE USE ONLY:

	AMOUNT
ADJUSTED INCOME:	

14. ESTIMATED HOUSEHOLD EXPENSES:

EXPENSES	AMOUNT/Monthly	AMOUNT/Yearly
Rent (House, Apartment, etc.)		
House Payment		
Home Owners Insurance		
Electric & Hot Water		
Gas/Heating Oil		
Telephone		
Automobile Payment(s)		
Automobile Insurance		
Health & Life Insurance		
Medical & Dental Expenses (Out-of-Pocket)		
Food & Consumable Items		
Child Care		
Clothing		
Education		
Child Support		
Other Expenses (Attach Schedule)		
TOTAL ANNUAL HOUSEHOLD EXPENSES:		

15. OUTSTANDING LOANS:

Loan	Institution	Purpose	Due Date	Balance
Loan #1:				
Loan #2:				
Loan #3:				

16. SAVINGS & INVESTMENTS:

Account	Institution	Source	Type	Balance
Checking:				
Savings:				
Investments:				
401(k) – IRA:				

AUTHORIZATION FOR RELEASE OF INFORMATION

I, _____, hereby authorize all medical care providers treating my medical condition stated on this application to release protected health and medical information to the Lions of Michigan Service Foundation, Inc. (Lions of Michigan Foundation).

I further understand that if my application is funded in whole or in part, the Lions of Michigan Foundation may elect to identify me by first initial and last name, my home community, the general nature of the medical service provided, for example eye surgery, and the amount funded in its promotional materials.

In signing this application, I hereby authorize the use of this information for the purposes indicated, and I release the staff, officers, and representatives of the health care providers, the Lions of Michigan Foundation, the sponsoring Lions Club and District, and all other organizations listed on this application from all legal liabilities relative to the release of the information requested on this application. I do understand that I have a right to refuse to sign this authorization.

Signature of Applicant/Guardian

Date

It is understood by all parties that any funds or equipment provided by the Lions of Michigan Foundation shall be used for the intent and purpose stated in this application. Any unused funds or equipment must be returned in a timely manner.

Signature of Applicant/Guardian

Date

Signature of Lions Club/District Representative

Date

Signature of Lions of Michigan Foundation Trustee

Date

Recommendation of Lions of Michigan Foundation Trustee:

