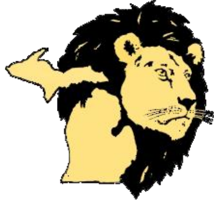
LIONS OF MICHIGAN FOUNDATION



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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. **APPLICANTS 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. **APPLICANTS 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:

A federal tax return, FORM 1040, and all related schedules must be attached to the application unless the applicant is not required to file an income tax return. Applicants who are not required to file a federal tax return must submit a SIGNED WRITTEN EXPLANATION. The application will not be processed without the required PROOF OF INCOME.

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. ESTIMATED HOUSEHOLD EXPENSES:

EXPENSES	AMOUNT/Monthly	AMOUNT/Yearly
Rent (House, Apartment, etc.)		
House Payment		
Property Taxes		
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:		

14. OUTSTANDING LOANS:

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

15. SAVINGS & INVESTMENTS

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

INFORMATION RELEASE & UNDERSTANDING

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), and I hereby attest that, to my knowledge, all information is accurate.

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, and the general nature of the medical service provided 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:

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