Lions Sight and Tissue Foundation

LIONS VISION SERVICES
P.O. Box 191121, Dallas, TX 75219-8121
PHONE (972) 276-1250 FAX (469) 533-1707
REFERRAL FOR EYEGLASS ASSISTANCE

Social Worker's Name: _____ Phone: _____

Agency Name: _____ Fax: _____

Which LENSCRAFTER'S would be most convenient for the client: _____

Client must already have a current prescription.

Income information must be sufficient to determine need for assistance.

Please fax the client's prescription to LS&TF along with this form.

CLIENT CONFIDENTIAL

Client's Name: _____ Phone: _____

Address: _____ City: _____ Zip Code: _____

Soc. Sec. No.: _____ Date of Birth_____ No. In Household: _____

Total Household Income (All sources): _____ Are you on Medicaid Yes: _____ No: _____

Do you have Insurance that covers vision exams/glasses? Yes: __ No: __ If yes Name of Insurance Co.: _____

I swear or affirm that the above information is true, that we meet the above conditions and that me, or my child does qualify for the free Glasses. Additionally, I am hereby authorizing FULL disclosure of the results of my or my child's vision examination, provided by the Lions Sight & Tissue Foundation and/or its partners. This information may be shared only with the following individuals: LENSCRAFTERS, Inc. Or another LS&TF program partner. I understand that I may, at any time revoke this authorization in writing, however, by doing so I understand that I will forfeit any services provided by the Lions Sight & Tissue Foundation and/or its partners. I understand if an unauthorized disclosure is made, I may file a formal complaint with the United States Department of Health and Human Services.

_____Client, Parent/Guardian Signature _____

Printed Name

(LS&TF USE ONLY)

DATE: _____

LENSCRAFTERS: _____

Please accept _____ as a recommended recipient for the Gift of Sight Foundation.

The Lions Sight and Tissue Foundation Tax Number_____

Respectfully:

Lion _____

Print Signature

Lions Sight and Tissue Foundation

For The Social Worker

Our current requirements for eyeglass assistance are:

1. The referral must be completed by the social worker, not the client.
2. The client must already have a current prescription.
3. The prescription must not be more than a year old.
4. Please fax the prescription to LS&TF along with the Referral Form.
5. Referrals will not be accepted until the client has a current prescription.
6. All Medicaid clients should contact Medicaid since they are covered for eye exam and glasses every two years. Please fax a completed form to LSTF at the fax number listed above.

Upon approval, a form will be faxed to you with the name and location of the LENSCRAFTERS selected. You can then notify your client who they need to contact. They need to let LENSCRAFTERS know they were sent to them by the LS&TF as part of the Gift of Sight Program. The LS&TF will not contact your client. Your client does not need to take a copy of the referral form to LENSCRAFTERS, only their prescription. At the same time a voucher with our approval will be faxed to the appropriate LENSCRAFTERS.

THE FOLLOWING INFORMATION IS ON LENSCRAFTERS IN THE DFW METROPLEX AREA.

ARLINGTON:	THE PARKS MALL APPOINTMENT REQUIRED	LOCATED AT UPPER LEVEL OUTSIDE SEARS TUESDAY - WEDNESDAY - THURSDAY
DALLAS:	NORTH PARK SHOPPING CENTER APPOINTMENT REQUIRED	LOCATED AT UPPER LEVEL BY NEIMAN MARCUS
DALLAS:	SOUTHWEST CENTER MALL APPOINTMENT REQUIRED	LOCATED AT UPPER LEVEL OUTSIDE DILLARDS MONDAY THROUGH THURSDAY 10 AM - 12PM
DALLAS:	VALLEY VIEW CENTER APPOINTMENT REQUIRED	LOCATED AT LOWER LEVEL OUTSIDE FOLEYS MONDAY THROUGH THURSDAY 10:00 AM - 1:00 PM
FRISCO:	STONEBRIAR CENTRE APPOINTMENT REQUIRED	LOCATED AT UPPER LEVEL OUTSIDE FOLEYS MONDAY THROUGH FRIDAY
IRVING:	IRVING MALL APPOINTMENT REQUIRED	LOCATED AT UPPER LEVEL OUTSIDE DILLARDS TUESDAY, WEDNESDAY, THURSDAY 11:00 AM- 7:00 PM
LEWISVILLE:	VISTA RIDGE MALL APPOINTMENT REQUIRED	LOCATED AT UPPER LEVEL OUTSID DILLARDS SUNDAY THROUGH SATURDAY
MESQUITE:	TOWN EAST MALL APPOINTMENT REQUIRED	LOCATED AT UPPER LEVEL OUTSIDE DILLARDS TUESDAY & THURSDAY 1:30 PM OR 3:30 PM
PLANO:	COLLIN CREEK MALL APPOINTMENT REQUIRED	LOCATED AT STREET LEVEL ENTRANCE NEAR SEARS MONDAY THROUGH FRIDAY

IN MOST CASES GLASSES WILL BE MADE IN ABOUT TWO (2) HOURS.
IF YOU HAVE ANY QUESTION, PLEASE LEAVE YOU NAME AND PHONE NUMBER ON THE VOICE MAIL AT (972) 276-1250, AND WE WILL RETURN YOUR CALL.

Lions Sight and Tissue Foundation

LIONS VISION SERVICES

TELEFONO (972) 276-1250 FAX (469) 533-1707

Aplicacion para Asistencia de Anteojos

Nombre del trabajador social: _____ Telefono: _____

Nombre de Agencia: _____ Fax: _____

Cual tienda LENSCRAFTER'S estara mas conveniente para la familia: _____

Cliente debe de tener receta corriente. Informacion de Ingresos debe de ser suficiente para determinar necesidadd para asistencia. Aplicacion debe ser de un trabajador social y de una agencia reconocida.

Please fax the client's prescription to LS&TF along with this form.

Confidencial de Cliente

Nombre de Cliente: _____ # de Telefono: _____

Domicilio: _____ Ciuidad: _____ Zona Postal: _____

de Seguro Social: _____ Fecha de Nacimiento: _____ # en familia: _____

Ingresos Total (todos Recursos): _____ Esta usted en Medicaid si: _____ no: _____

Tiene usted aseguranza que cubre examen o anteojos? si: __ no: __ Nombre de aseguranza: _____

Yo afirmo que la informacion es verdad, que nosotros cumplimos con las condiciones y que yo o mi nino/a calificamos para tener anteojos o examenes gratis. Tambien yo autorizo revelacion total del examen proveido por Lions Sight & Tissue Foundation. Esta informacion puede ser compartida solamente con la enfermera de la escuela. LENSCRAFTERS, Inc. or another LS&TF program partner, Yo entiendo que yo puede rechazar esta autorizacion en escrito, pero con hacer eso, yo entiendo que yo pierdo todos los derechos de servicios proveidos por el Club de Lions Sight & Tissue Foundation y sus patrocinadores. Yo entiendo que si una revelacion no es autorizada, Yo puedo presentar una demanda con los Servicios de Salud y Humanos de los Estados Unidos.

_____firma Cliente/padre/guardiant_____ letra en molde

(LS&TF USE ONLY)

DATE: _____

LENSCRAFTERS: _____

Please accept _____ as a recommended recipient for the Gift of Sight Foundation.

The Lions Sight and Tissue Foundation Tax Number _____

Respectfully:

Lion _____

Print Signature

Revised May 4, 2012