MONTANA LIONS SIGHT & HEARING FOUNDATION
Individual Assistance Application Instructions

The application process can take time and can depend on various factors including the number of requests we have, the urgency of those requests and available funding. **PLEASE BE PATIENT.**

PREPARED BY APPLICANT – Sections 1, 2, 3, 4 and 6C: It will be the applicant's responsibility to complete the application, provide supporting documents and return the application to: Montana Lions Sight & Hearing Foundation; PO Box 1925; Columbia Falls, MT 59912; email: LionJessicaFausey@gmail.com.

Section 2A: **This is the critical part of the application. Timely and accurate information is required.**
Provide supporting documents/narrative that will help trustees determine financial need.
Current Monthly Income: Provide accurate *monthly income* for all categories. Also, you MUST provide documentation of proof of income statement(s); W-2, tax page showing AGI, payroll stubs, bank statements, Social Security, Disability, Unemployment, Food Stamps, HUD Housing, etc.
Current Monthly Expenses: Provide accurate *monthly expenses* for the applicable listed categories. Monthly expenses do vary, provide an amount that is as accurate as possible. Provide explanatory notes that might possibly help trustees understand your financial situation.
Mortgage: If you have a mortgage please provide an estimate as to how much is still due on the mortgage.
Credit Card Debt: Provide total credit card debt at time of completing this application.
Assets: Item #2 general estimate on items of special value (i.e. collectibles, computers, recreational equipment / vehicles, etc.); *#3 Checking Account*: estimated amount left in checking account at the end of the month, please provide a current statement; #4 Stocks/Money Market Accounts/Bonds: estimated value; #5 Motor Vehicles: estimated value of all household vehicles; #6 Savings Account: estimated amount held in savings account(s).

Section 3: Read and sign statement protecting your right to privacy. Review the WIC guidelines (page 1).

Section 5: Prepared by the medical care professional. Describe the condition and the medical recommendation required to eliminate the condition. Be specific regarding cost of equipment, services, care, etc.

Note: If this is an application for hearing aids and you have not had a hearing exam do not complete this section. The Foundation administrator will work with the applicant to select an audiologist.
It is the applicant's responsibility to keep in contact with the medical service provider regarding the service, if approved, to help make sure that the process progresses.

SUMMARY OF PROCESSING STEPS

- Complete the application following the steps listed above. Return the application and **ALL** supporting documents to the Foundation administrator or to a local Lions Club (if club contact information is known).
- The application will come to the Foundation administrator where it will be reviewed for accuracy and completeness.
- A local Lions Club must approve the application. The application will again be reviewed for accuracy and completeness.
- The application will be reviewed by the Foundation's trustees or executive committee. Trustees will make the final decision regarding approval/non-approval.
- The applicant will be notified, in writing, of the trustees' decision and be provided instructions as to the next steps in the process. **A personal financial payment, based on ability to pay, will be required at that time to proceed.**
- The Foundation administrator will work with the applicant and medical service provider to make sure that the approved medical service is provided in a timely manner.
- Payments will only be made to the appropriate medical service provider(s). Payments will be made by the Foundation treasurer.
- This process does take time to complete. Applicants will always be notified, in writing, of significant progress in processing the application. **Please be patient.** Processing make take as long as 12 weeks.
- If the applicant has not completed the entire application process within 16 weeks, including the receipt of services, the applicant will have to re-apply for financial assistance.

Montana Lions
Sight & Hearing Foundation

Lion Jessica Fausey, Administrator
PO Box 1925; Columbia Falls, Montana 59912

Phone: 406.253.1737
LionJessicaFausey@gmail.com

The Montana Lions Sight & Hearing Foundation (MLS&HF) was created in 1980 with the specific purpose to provide financial assistance to Montana citizens with a financial and medical need associated with sight, hearing and/or speech problems. Qualified applicants receive quality medical treatment with dignity, confidentiality, and compassion.

The Foundation will not be responsible for any medical service related costs that have not been given prior written approval by the Foundation administrator.

If you have questions about eligibility, the application, or about other Lions programs please contact the Montana Lions Sight & Hearing Foundation administrator at 406.253.1737; LionJessicaFausey@gmail.com.

Eligibility Guidelines

1. All applicants must live in Montana and be a permanent resident of Montana.
2. The requested treatment or surgery must be a vision, hearing and/or speech related impairment. There are limitations and guidelines for specific procedures.
3. Consideration will be given to applicants whose income eligibility follows the Montana WIC Guidelines.

July 1, 2025 – June 30, 2026 WIC Guidelines

Household Size	Annual Income	Monthly Income
1	$28,953.00	$2,413.00
2	$39,128.00	$3,261.00
3	$49,303.00	$4,109.00
4	$59,478.00	$4,957.00
5	$69,653.00	$5,805.00
6	$79,828.00	$6,653.00
7	$90,003.00	$7,501.00
8	$100,178.00	$8,349.00

Each Additional Member Add (monthly): $848.00

THE APPLICANT MUST COMPLETE ALL ACTIONS ASSOCIATED WITH THE APPLICATION WITHIN 16 WEEKS AFTER RECEIPT OF THE APPROVAL LETTER. FAILURE TO COMPLETE THE PROCESS WITHIN THE ESTABLISHED TIME LIMIT WILL REQUIRE THE APPLICANT TO SUBMIT A NEW APPLICATION.

ALL QUESTIONS MUST BE ANSWERED If any do not apply, write "N/A" in the spaces provided

Section 1: Applicant Information PLEASE PRINT AND SIGN

The MLS&HF is committed to an anti-discrimination policy in all of its programs and services. This includes, but is not limited to, race, ethnicity, gender, religion, age, marital status, language, disability, or immigration status.

First Name:	Middle Initial	Last Name		Age or Date of Birth (mm/dd/yyyy)
Mailing Address			Apartment #	Phone#
City	State	Zip	County	Alternate Phone #
Home Address			Email Address	
How Long Have You Lived in Montana? (months/years)			Gender Male Female	
Parent/Guardian Full Name (if applicable):		Relationship to Applicant		
APPLICANT or PARENT/GUARDIAN SIGNATURE:				
SEEKING SERVICE FOR (MARK ONE): **SIGHT** ☐ **HEARING** ☐ **SPEECH** ☐				

Section 2: Financial Information

Do you have any insurance coverage? Private Insurance Medicare Medicaid Other

Please list all household members (additional members should be listed on a separate sheet if needed):

First Name	Last Name	Relationship	Age
First Name	Last Name	Relationship	Age
First Name	Last Name	Relationship	Age
First Name	Last Name	Relationship	Age

- **You must provide proof of income for all household income earners (i.e. W-2, tax page showing AGI, payroll stubs, bank statements, Social Security, Disability, Unemployment, Food Stamps, HUD Housing, etc. attach a copy of your benefit or approval statement).**

Applications received without supportive documentation will not be processed.

SECTION 2A: IF THERE ARE SPECIAL INCOME/EXPENSE CIRCUMSTANCES PLEASE PROVIDE A WRITTEN NARRATIVE EXPLAINING THE SITUATION(S).

HOUSEHOLD MONTHLY GROSS INCOME		HOUSEHOLD MONTHLY EXPENSES	
(Income before taxes Applicant Wages	$	***(Average from month to month)*** Mortgage	$
		Rent	$
Spouse or Partner Wages	$	Utilities (Phone, Internet, gas, water, sewer, etc.)	$
Parent/Guardian Wages	$	Groceries	$
Social Security Benefits	$	Vehicle Payments	$
Disability Benefits	$	Transportation (fuel, tax, maintenance)	$
Unemployment Benefits	$	Vehicle Insurance	$
Retirement/Pension	$	Life Insurance	$
Investments	$	Health Insurance	$
Child Support/Alimony	$	Home/Rental Insurance	$
Food Stamps	$	Credit Card Payment	$
Rental Income	$	Taxes: Federal, State, Property	$
Other Income	$	Other Expenses (provide brief explanation)	$
Total Monthly Income:	$	**Total Monthly Expenses:**	$

ALL SUPPORTING DOCUMENTS MUST BE ATTACHED TO THE APPLICATION. A STATEMENT (TAX PAGE SHOWING AGI, W-2 WAGE STATEMENT, SOCIAL SECURITY STATEMENT, BANK STATEMENT, ETC) PROOF OF ANNUAL INCOME MUST BE PROVIDED WITH THIS APPLICATION. IDENTIFICATION NUMBERS CAN BE REMOVED.

MORTGAGE

If you have a mortgage, what is the balance? $_____

TOTAL CREDIT CARD DEBT

Provide "total credit card debt" $ _____

ASSETS

1. **REAL ESTATE (estimated value)** $ _____
2. **PERSONAL PROPERTY/CASH** $ _____
3. **CHECKING ACCOUNT** $ _____
4. **STOCKS, MONEY MARKETS BONDS, CD'S** $ _____

TOTAL ASSETS (add #1- #8) $ _____

5. **MOTOR VEHICLES** $ _____
6. **SAVINGS ACCOUNT** $ _____
7. **OTHER INVESTMENTS**
   - a. _____ $ _____
   - b. _____ $ _____
8. **OTHER ASSETS**
   - a. _____ $ _____
   - b. _____ $ _____

I CERTIFY THAT ALL INFORMATION STATED IS TRUE. I GRANT PERMISSION TO THE FOUNDATION AND THE SPONSORING LIONS CLUB TO VERIFY THE ACCURACY OF THIS REPORT. IF THE FINANCIAL CONDITION CHANGES SUBSTANTIALLY, I AGREE TO GIVE PROPER NOTIFICATION TO THE FOUNDATION OR SPONSORING LIONS CLUB.

_____ _____

Applicant or Parent/Guardian Signature **Date**

Section 3: Authorization for Disclosure of Protected Health Information

I authorize the disclosure of my protected health information as described herein. I understand that this authorization is voluntary and made to confirm my medical needs. I understand that the Montana Lions Sight & Hearing Foundation is not subject to federal and state health privacy laws and that subsequent disclosure by the Montana Lions Sight & Hearing Foundation to other person(s) or organization(s) may or may not be protected by those laws.

I authorize the following organization and their qualified partners to receive my health information:

Organization: *Montana Lions Sight & Hearing Foundation/Foundation Board of Directors*
Address: *PO Box 1925 Columbia Falls, Montana 59912*
Phone: *406.253.1737*

Specific description of the purpose for disclosure:

The undersigned is requesting charitable assistance from the Montana Lions Sight & Hearing Foundation. Any requested health information will pertain to the specific requested treatment or surgery and the treatment plan.

I have had the opportunity to read and consider the contents of this authorization.

_____ _____

Applicant or Parent/Guardian Signature **Date**

Section 4: Please provide a short explanation of medical need. Please provide any additional information that might give sponsoring clubs and/or Foundation trustees a better understanding of your situation and assistance request. Attach additional sheets as needed.

Section 5: DIAGNOSIS AND RECOMMENDATION:

****ASK YOUR EYE CARE PROFESSIONAL, HEARING OR SPEECH SPECIALIST OR MEDICAL SERVICE PROVIDER TO COMPLETE THIS SECTION. PROVIDE ANY WRITTEN STATEMENT THAT MIGHT HELP FOUNDATION TRUSTEES EVALUATE YOUR MEDICAL CONDITION.****

DIAGNOSIS:

RECOMMENDATION:

ESTIMATED TOTAL COST OF ALL SERVICES:

Provide eye care professional, hearing or speech specialist or medical service provider contact information. If you have not seen an audiologist one will be appointed by the Foundation to provide your hearing aids.

Facility: _____

Provider Name: _____

Mailing Address: _____

City, State and Zip: _____

Phone #: _____ **Fax #:** _____

Email Address: _____

MEDICAL SERVICE PROVIDER SIGNATURE: _____ **DATE:** _____

*APPLICANT: COMPLETE SECTIONS – 6C

6A. TOTAL COST OF ALL SERVICES RECEIVED TO BE RECEIVED $_____

6B. LESS TOTAL AMOUNT TO BE PAID FROM OTHER SOURCES $_____

6C. **A ONE-TIME PERSONAL FINANCIAL PAYMENT, BASED ON ABILITY TO PAY, IS REQUIRED. HOW MUCH CAN YOU PAY FOR THE SERVICES REQUESTED? APPLICANT AGREES TO MAKE SAID PAYMENT PRIOR TO SERVICES RENDERED.** $_____
(MLS&HF reserves the right to refuse reimbursement of said payment)

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*SPONSORING LIONS CLUB: COMPLETE 6D ALONG WITH THE BOTTOM OF THE APPLICATION

6D. LESS AMOUNT OF LIONS CLUB'S CONTRIBUTION. THE CLUB IS REQUESTED TO CONTRIBUTE $300.00 OR 10% OF THE ESTIMATED COST OF THE PROCEDURE, WHICHEVER IS GREATER $_____

TOTAL AMOUNT OF FINANCIAL ASSISTANCE REQUESTED $_____

SPONSORING LIONS CLUB REPORT

1. _____ ALL COSTS HAVE BEEN CONFIRMED.

2. _____ APPLICATION IS APPROVED WITH THE UNDERSTANDING THAT THE CLUB IS ONLY ABLE TO PROVIDE $_____ TOWARD THE TOTAL AMOUNT REQUESTED, AND ASKS THE FOUNDATION FOR ASSISTANCE TO COVER THE BALANCE NEEDED. IF THE AMOUNT OF THE CLUB'S FINANCIAL COMMITMENT CHANGES, A REFUND WILL BE MADE BY THE FOUNDATION.

COMMENTS:_____

_____

To the best of my knowledge, this applicant has a need for vision or hearing treatment or surgery as defined in the attached medical chart notes or referral letter. I further attest the applicant appears to meet the financial eligibility requirements as confirmed in the attached financial support information. Based on my review of the application and the attached documentation, I and the Lions Club support this request for financial assistance.

Lion Club Representative Signature: _____ Date: _____

Lions Club Name: _____ Phone #: _____

Email Address: _____