



District 11-E2

Procedure for Dispersement of Diabetes and Medical Assistance Funds (Including Speech and Hearing Funds)

1. A Diabetes and Medical Assistance Committee will be established annually along with a Hearing and Speech Committee. The District Governor shall appoint a Chair for each committee. Members of each committee will be recruited by the appointed chair and approved by the District Governor. Each committee should have a minimum of three members.
2. Potential recipients of funds will complete the attached application and submit to the local club in their community. Any applications submitted to the Medical Assistance Chair will be forwarded to the appropriate local club. Blank applications will be made available to local clubs via the District Newsletter and website. Applications can also be obtained from the Chair or any Cabinet member. These applications will take the place of the current Diabetes Assistance applications.
3. Local club will evaluate application to determine need, whether other options have been exhausted, and evaluate club resources for potential funding.
4. If the club feels that assistance is not warranted, the local club will notify the applicant that funding was not approved. If the club feels that application is worthy of funding, the club will consider funding the need locally. If the local club is unable to provide the necessary funding, the application will be forwarded by the club to the Medical Assistance Chair with the signature of the current club president.
5. The Medical Assistance Chair will:
 - a. If the amount applied for is less than \$500, the Chair will forward application to committee members, and with the signature of at least one other committee member may approve the application, notify recipient, and request funding from District Treasurer.
 - b. If amount applied for is \$501 - \$1000, application will be reviewed by Cabinet and voted on at the next regular meeting. The Chair will then notify recipient, and request funding from District Treasurer.
 - c. If amount applied for is over \$1000, the local club and/or Lions of Michigan Service Foundation Trustees will assist with application to the Service Foundation for funding. Match funding may be provided by the Medical Assistance fund with approval of the Cabinet and input from the Medical Assistance Chair. If funding is not received, the Cabinet may vote to fund from the Medical Assistance fund.

6. Applicants will be eligible for funding from this account only once in a three year period unless otherwise approved by the Cabinet.
7. If the assistance required is of an emergent nature in the opinion of either the Medical Assistance Chair or the local club, it will not be necessary to wait until the next regularly scheduled Cabinet meeting in order to approve application. Instead, The Medical Assistance Chair or local club president will request an emergency vote of the Cabinet. This shall be conducted by the District Governor.
8. Medical assistance will be provided by either paying itemized bills directly or reimbursing recipient upon receipt of itemized receipts.
9. In the event that requests exceed resources, applications for assistance related to diabetes care shall take precedence over non-diabetes related expenses.
10. Files, including applications and records of actions taken will be maintained by the current Medical Assistance Chair for a period of seven (7) years, when they will be destroyed.



District 11-E2

Application for Assistance

Funding source: Diabetes General Medical Assistance
 Hearing Assistance Speech Assistance

Name: _____ Age _____ Phone _____

Address: _____ City, Zip _____

County _____ Family income: _____ Number of people

living in the home: _____ Source of income: _____

Medical insurance: None Medicare Spend down
 Medicaid Blue Cross Other (please indicate) _____

If you have medical insurance, is item or service covered under insurance? _____

If you do not have medical insurance, have you applied for assistance from FIA and what was the outcome? _____

Amount of assistance requested: _____ Assistance requested for (please be as specific as possible; attach additional documentation if necessary): _____

Is there any other information that you feel that the Lions need to know in order to evaluate your application for assistance?

By signing and submitting this application, I certify that the information is accurate to the best of my knowledge. I also give both the local Lions Club and District 11E-2 the authority to disclose this information to committee members to the extent necessary to evaluate this application for consideration of funding.

Signature of applicant or parent if applicant is a minor child

Date

Send completed application to Jan Kane, 1501 West Chisholm, Alpena, MI, 49707

Club Evaluation Form For Assistance

Local Club _____

Results of Evaluation

Recommend no funding Recommend funding for \$ _____

Funding source:

- Diabetes
- General Medical Assistance
- Hearing Assistance
- Speech Assistance

Club contact person _____

Phone _____ E Mail _____

Signature of Club President _____ Date _____

Actions of the Medical Assistance Chair _____
