PLANT CITY LIONS CLUB
SIGHT ASSISTANCE APPLICATION

Name: ______________________ Application #: __________

SSN: __________ Telephone: __________ Email: __________

Current Address: __________ City: __________ State: _____ Zip Code: __________

If at address less than 6 months, prior residence: __________ Are you able to work? __________

Employer: __________ How long: __________

Name of Insurance: __________ Do you have Medicaid? __________ Do you have Medicare? __________

If Unemployed, How Long: __________ When can you go back to work? __________ Type of Work you do: __________

Number in household: _____ Age & relationship of each member: __________

FINANCIAL INFORMATION:

Monthly INCOME of Household		Monthly EXPENSES of Household	
Your Income:		Mortgage / Rent:	
Father:		Telephone:	
Mother:		Cable or Satellite:	
Husband:		Water:	
Wife:		Electric:	
Others In Household:		Heating oil	
Aid Dependent Children:		Food or Food Stamps	
Alimony:		Vehicle Insurance:	
Child Support:		Gas:	
Disability Comp.		Medical Insurance:	
Food Stamps:		Doctors:	
Medicaid (include number):		Dentists:	
Medicare (A or A/B):		Prescriptions:	
Rental Income:		Clothing:	
Retirement Pension:		Child Support:	
Social Security:		Alimony:	
Unemployment Comp.		Other Expenses:	
Veteran's Pension:		Other Expenses:	
Your Savings Balance:		Other Expenses:	
Other Income:		Other Expenses:	
Total Monthly Income:		**Total Monthly Expenses:**	

Federal and state compliance provisions require us to ask the following information:		
Sex:	Male or Female	
Race:	Caucasian	
	African American	
	Hispanic/Latino	
	Asian	
	Indian	
	Other (Specify)	
Date of Birth:		
Age:		
United States Citizen?		Yes No
Are you a Legal Resident?		Yes No
United States Veteran?		Yes No
Difference + or -	$	

Describe your sight problem: __________

____

Date of Last Eye Examination: __________ Services Requested __________

Who referred you to the LIONS? __________

I am applying to the Lions Club for financial assistance for a vision examination, eyeglasses or surgery, if needed. I understand the information I give will be used to verify financial eligibility and also for referral to physicians or other vision care providers as necessary. I certify that all the above information is true and complete to the best of my knowledge.

__________ Signature of Applicant   __________ Date Signed   __________ Signature of Lions Club Witness

DO NOT WRITE BELOW THIS LINE

For Official Use Only:
The Sight Committee **APPROVED** the following:
Refer to Ophthalmologist for Examination: _________ Eyeglasses Only (patient has Rx): _________ Eyeglasses & Exam _________
Surgery or Medical Procedure: _________ Eye Prosthesis: _________ Other: __________

A majority of the Sight Committee **DID NOT APPROVE** this application. _________ Review Date: __________ Initial __________