Lions Sight Foundation of Clark County
P.O. Box 1804
Vancouver, WA 98668-1804

This committee meets the first Tuesday of each month.

Applicants must complete ALL sections of this TWO PAGE application to be eligible for services. Incomplete applications could result in delay or denial of service.

PRINT

| Last Name First Name Middle Initial | Date of Birth Age | |
|---|---|---|
| Parent or Guardian Name(s) (if applicant is under 18 years of age) | | |
| Address City State Zip | Driver License Number & State | |
| Home Phone | Work Phone | Cell Phone |
| List previous address(s), if less than one year at the above address. (Attach additional sheets as needed) | | |
| List ALL household members - show relationship and ages of each. (Attach additional sheets as needed) | | |
| Are you a citizen of the USA?(circle one) Yes / No<br>If NO, Do you have a United States PERMANENT RESIDENT CARD? (circle one) Yes / No | Do you live in Clark County? (circle one) Yes / No<br>How long have you lived in Clark County? Yrs ________ | |
| Occupation | Employer and Address | Work Phone Number |
| Is applicant a student? | List name of school attending | Grade or Year |
| List names of all other students in the household on free or reduced lunch programs | | |
| Does applicant have Vision Insurance coverage? (Circle one) NO INSURANCE / YES<br>If YES List Provider ______________________________ | | |
| Circle your appropriate Medical coverage:<br>Medical coupons Medicare Medicaid Employer or Private Insurance Other | | |
| Person assisting applicant with this application (if any)<br>Name Phone | | |
| If referred by an organization, provide the Organization Name, Phone Number and Contact Person | | |
| List services needing help with: Eye Exam / Eye Glasses - Low Vision Aid - Other | | |
| Applicants choice of doctor: Date of your last eye exam: | | |
| Why I need help with these services? | | |
| Signature of Applicant Date | | |

Signature of Applicant confirms this is a true and accurate statement of their personal current circumstances.

COMPLETE ALL SECTIONS ON THE REVERSE SIDE

COMPLETE ALL BLANKS

MONTHLY INCOME FOR ENTIRE HOUSEHOLD

| | |
|---|---|
| "Take Home" pay from Employment for the entire household | $ |
| Social Security Benefits (total for all family members) | $ |
| Child Support (actual amount you receive each month) | $ |
| Retirement Benefits | $ |
| Veteran's Benefits | $ |
| Public Assistance (AFDC, GAU, SSI, Food Stamps) | $ |
| Unemployment Benefits (weekly x 4 + ?) | $ |
| Other Income (specify) | $ |
| TOTAL MONTHLY INCOME | $ |

If you have little or no income, fully explain how you are able to support yourself; for example, who you are living with and who is supporting you. Use a separate sheet of paper if necessary.

______________________________________________________________________________

PERSONAL ASSETS

| | | | | | List Value |
|---|---|---|---|---|---|
| Vehicle #1 | Year | Make | Plate # | State | $ |
| Vehicle #2 | Year | Make | Plate # | State | $ |
| Value of Boat, RV or Other Recreational Equipment | Year | Make | Plate # | State | $ |
| Savings Account(s) | | | | | $ |
| Checking Account(s) | | | | | $ |
| Stocks, Bonds, CD's, etc | | | | | $ |
| Value of Home and other Real Estate | | | | | $ |
| Anything else of value | | | | | $ |
| TOTAL VALUE OF ASSETS | | | | | $ |

MONTHLY EXPENSES

| | |
|---|---|
| Housing ( Circle One) Rent or Mortgage Payment | $ |
| Food | $ |
| Utilities: Electric | $ |
| Water | $ |
| Telephone | $ |
| Cell phone | $ |
| Vehicle Fuel | $ |
| Car Payment(s) (specify vehicle and amount each) | $ |
| Insurance Cost | $ |
| Medical Bills | $ |
| Dental Bills | $ |
| Medical/Dental Insurance | $ |
| Loan Repayment (specify) | $ |
| Credit Card Payments | $ |
| Other Monthly Expenses (specify) | $ |
| MONTHLY EXPENSES | $ |

THIS SECTION FOR USE OF LIONS SIGHT FOUNDATION COMMITTEE Form # LSFCC 08/2017

APPROVED DOCTOR ______________________________ VOUCHER # ____________

DENIED REASON ______________________________________________________

LSFCC AUTHORIZING SIGNATURE ____________________________ DATE __________