



# WV LIONS APPLICATION FOR SIGHT OR HEARING ASSISTANCE

<b>Sponsoring Lions Club</b>	<b>Dist</b>	<b>Date</b>
<b>Lion Member submitted</b>	<b>Phone</b>	
<b>Assistance being requested</b>		
<b>Referring Doctor</b>	<b>Phone</b>	

**Complete and return this application to the Lion or Lion Club which made it available to you.**

Your answers to personal and private information will be important in determining your qualifications for assistance through the West Virginia Lions Sight Conservation Foundation (WVLSFCF). If you fail to answer any of the questions, or don't give acceptable reasons why you did not answer, your application will be delayed or denied. Your answer and attached supporting information will be treated with the utmost confidence by Lions and the service providers with whom Lions work. If this application is approved, you will receive service from professional technicians, physicians and medical facilities with whom Lions work. Individual Lions, Lions Clubs, the WVLSFCF and Lions Club International accept no responsibility for the accuracy or reliability of these services.

**By your signature on this application, you have read and agreed to the above terms and conditions.**

### Income: Yearly

Applicant Name		Phone		Veteran	
Address				Food Stamps	
City/State/Zip				Unemployment	
Social Security #	XXXXXXX	Sex		Date of Birth	Pension/Retirement
SSI (Yes/No)	Aid from other sources			Social Security	
Employer				Alimony	
Emp. Address				Child Support	
Phone	Wages per month	\$		Years employed	Public Assistance
Reason for leaving				Case #	
Spouse's Name		Phone			
Employer		Wages per month		\$	<b>TOTAL INCOME</b>

### Expenses: Yearly

Number of dependents living with you?			#		Gas	
Name	Age	SS #	XXXXXXX	Electric		
Name	Age	SS #	XXXXXXX	Water		
Name	Age	SS #	XXXXXXX	TV/Cable		
Total income yearly	\$	Total in checking/saving			Telephone/Cell	
Other assets				Real Estate Tax		
Own your home?	Value \$	\$	Payments \$	Property Tax		
Do you rent?	Monthly Rent	\$	Utilities included	Life Insurance		
List vehicle(s): year, model				Auto Insurance		
Value	\$	Payments	\$	Insurance	\$	Supplemental Ins.
				Prescription		
				<b>TOTAL EXPENSE</b>		

Applicant's Signature \_\_\_\_\_ Date: \_\_\_\_\_

Parent/Guardian Signature \_\_\_\_\_ Date: \_\_\_\_\_

### REPORT OF SIGHT FOUNDATION SERVICE COORDINATOR

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Signature \_\_\_\_\_ Approved ( ) Disapprove ( ) Date: \_\_\_\_\_