WV LIONS APPLICATION FOR SIGHT OR HEARING ASSISTANCE

Sponsoring Lions Club		**Dist**		**Date**	
Lion Member submitted			**Phone**		
Assistance being requested					
Referring Doctor			**Phone**		

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 (WVLSCF). 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 WVLSCF 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 #	XXXXXX	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	**$**				**TOTAL INCOME**	

Expenses: Yearly

Number of dependents living with you?					#			Gas	
Name		Age		SS #	XXXXXX			Electric	
Name		Age		SS #	XXXXXX			Water	
Name		Age		SS #	XXXXXX			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	
								TOTAL EXPENSE	

Applicant's Signature _____ Date: _____

Parent/Guardian Signature _____ Date: _____

REPORT OF SIGHT FOUNDATION SERVICE COORDINATOR

_____

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Signature _____ **Approved ( ) Disapprove ( ) Date:** _____