SANTA CRUZ HOST LIONS CLUB

Assistance Application for Eye Exam/Glasses
(To Be Completed by Applicant)

INSTRUCTIONS: After completing this form, mail to **Santa Cruz Host Lions Club**
P. O. Box 477; Santa Cruz, CA 95061 **or** fax to (831) 423-2352

Applicant's Name: ______________________________ DOB ________

Address ______________________ City ____________ State ____ Zip ________

If A Minor, Parents or Guardian Name: ______________________________

Address(If Different) ______________________ City ____________ State ___ Zip ______

Phone ______________ How Long Have You Resided in Santa Cruz County ____________
(must be included)
Alternate Contact Name ______________________ Phone Number ____________

Are you a legal resident of the United States of America? ______________________

Net Monthly Salary $______________ Number of Dependents on net income ____________

Do You Currently Have Vision Insurance? ______________________________

Do you have Medi Cal? ________ Medi Cruz? ________ Medicare or other insurance? ________

IF APPROVED YOU WILL BE REQUIRED TO MAKE A CO-PAYMENT OF $25.00
(DUE AT THE TIME OF SERVICE)

Please briefly explain how you specifically will benefit from the Lions Eye Fund Support:

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APPLICANT'S SIGNATURE ______________________________ DATE ____________

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LIONS CLUB AUTHORIZATION

APPROVED BY ______________________________ **DATE** ____________

APPROVED BY ______________________________ **DATE** ____________