Lake Chelan Lions Club

Application for Sight and Hearing Assistance

Please print clearly

Patient's name: _____Date of Birth:_____
If patient is a minor,
parent's or guardian's name:_____

Mailing Address:_____P.O. Box_____

City: _____ State: _____ Zip: _____

Home phone: _____ Mobile phone: _____

Service Requested: Eye Exam___ Glasses___ Hearing Test___ Hearing Aids___
Patient's or Parents' Monthly Gross Income: $ _____ Number of dependents ___
Patient Spouse's Monthly Gross Income: $ _____Savings: $ _____
Other income (*please explain*): _____

Please include proof of income; Income Tax Filing or copies of Pay Stubs.

Do You Have: Medicare___ Medicaid___ DSHS___ VA___ Health Ins.___ Other___
I am willing to pay at least $20.00 towards the services. Yes___ No___
Have you received services from the Lions Club in the past. Yes___ No___ Date_____

Please provide either last year's tax returns or current income verification.

I certify that I do not have the finances to meet this need. I have sought assistance from the County, State and Federal programs available and do not qualify.
The information provided here is true and correct and I (we) attest to its accuracy.

_____Date:_____
(Patient's signature)

_____Date:_____

(Parent's or guardian's signature, if the patient is a minor)

_____Date:_____
(Spouse's signature)

Please use another page to give additional pertinent information you think would be helpful to Lake Chelan Lions as we review your request for assistance.

All Applications are kept confidential.

Mail application to Lake Chelan Lions Club Sight and Hearing Chairperson

Shannon By-quist Freels
Sight and Hearing Chair
PO Box 1521
Chelan, WA, 98816

Approved: Yes___ No___Date:_____

Signature: _____