Florida Lions Foundation for the Blind, Inc.

ELIGIBILITY APPLICATION FOR FINANCIAL ASSISTANCE

APPLICANTS NAME: _____ MARITAL STATUS: _____

RESIDENTIAL ADDRESS: _____

MAILING ADDRESS: _____

OWN/RENT: _____ HOW LONG HAVE YOU LIVED HERE? _____

PREVIOUS ADDRESS: _____

HOME PHONE: ( ) _____ CELL PHONE: ( ) _____ EMAIL ADDRESS: _____

SSN: _____-____-_____ SPOUSE SSN: _____-____-_____ APPLICANTS DATE OF BIRTH: _____/_____/_____ AGE: _____

GENDER: M_____ F_____ DIABETIC: YES_____ NO_____

IF MINOR, PARENT/GUARDIAN NAME: _____

ADDRESS IF DIFFERENT THAN ABOVE: _____

NUMBER OF DEPENDENTS_____ GREEN CARD # (IF APPLICABLE) _____

EMPLOYER: _____ EMPLOYER PHONE: ( ) _____ FULL TIME/PART TIME: _____

MONTHLY HOUSEHOLD INCOME

(list all sources)

TOTAL HOUSEHOLD INCOME: $_____WAGES/SALARY/TIPS: $_____ SOCIAL SECURITY: $_____

UNEMPLOYMENT/WORKERSCOMP: $_____ RETIREMENT/PENSION: $_____ SSI/SSD/DAV: $_____

INTEREST/DIVIDENDS: $_____ WELFARE/PUBLIC ASSIST/FOOD STAMPS: $_____ CHILD SUPPORT: $_____

SELF EMPLOYED: $_____ OTHER INCOME: $_____

MONTHLY HOUSEHOLD EXPENSES

(list all expenses)

RENT/MORTGAGE: $_____ PHONE: ( ) _____ MEDICAL INS: $_____ VEHICLE INS: $_____

WATER/SEWER: $_____ CABLE: $_____ PRESCRIPTIONS: $_____ GAS: $_____

ELECTRIC: $_____ LOANS: $_____ OTHER: $_____ LOAN: $_____

FINANCIAL COMMENTS:

_____

_____

_____

_____

MEDICAL INSURANCE INFORMATION

MEDICARE NUMBER: _____ (A) OR (A & B) MEDICAID: _____

OTHER INSURANCE PROVIDER: _____ POLICY: _____

POLICY HOLDERS NAME: _____

DIVISION OF BLIND SERVICES DATE DENIED: _____ VOCATIONAL REHABILITATION DATE DENIED: _____

TYPE OF ASSISTANCE NEEDED: _____

_____

_____

_____

I hereby certify that the above information is correct and do hereby give my full consent to investigate.

_____ _____

Applicant Signature **Date**

_____ _____

Lion-Processor Signature **Date**

Lions Club Notes:

_____

_____

_____

_____

THIS FORM IS FOR LIONS CLUB USE ONLY

FLORIDA LIONS FOUNDATION FOR THE BLIND
PROJECTS FORM

CLIENT INFORMATION

Case # _____ Date Entered: _____ Foundation App: _____

Last Name: _____ First Name: _____ Middle Initial: _____

Address: _____

City: _____ State: _____ Zip Code: _____ Phone: ( ) _____

SSN: _____-_____-_____ Diabetic: Yes_____ No_____ Age: _____ Sex: _____ Monthly Income: $_____ # Dependents _____

CLUB/CHAIRPERSON INFORMATION

Sponsoring Club _____ District: _____ Sub-District: _____

Chairperson Name: _____

Address1: _____

City1: _____ State1:_____Zip Code1: _____ Phone1: _____

DOCTOR INFORMATION

Doctor Name: _____

Address2: _____

City2: _____ State2:_____ Zip Code2: _____ PHONE: ( ) _____ FAX: ( ) _____

Procedure: _____

ESTIMATED AMOUNTS

Surgery: $_____ Anesth: $_____ Facility1: $_____ Misc: $_____ Total: $ _____

FOR FOUNDATION USE ONLY DO NOT FILL IN BELOW APPROVED AMOUNTS

Surgeon $_____ Anesth $_____ Facility: $_____ Misc: $_____

Co-Pay: $_____ Savings: $_____ Foundation Funds: $_____

ACTUAL AMOUNTS PAID

Surgeon Paid: $_____ Surgeon Date: _____ Check1 #: _____

Anesth Paid: $_____ Anesth Date: _____ Check2 #: _____

Facility Paid: $_____ Facility Date: _____ Check3 #: _____

Misc. Paid: $_____ Misc. Date: _____ Check4 #: _____

Total Requested: $_____ Total Paid: $_____ Total Saved: $_____

Case is active until Date Completed is filled in Date Completed: _____

_____ _____

Club Sight Chairperson Signature **District Sight Chair Signature**