

# 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?** \_\_\_\_\_

**Social Security number** \_\_\_\_\_

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

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**APPLICANT'S SIGNATURE** \_\_\_\_\_ **DATE** \_\_\_\_\_

-----  
**LIONS CLUB AUTHORIZATION**

**APPROVED BY** \_\_\_\_\_ **DATE** \_\_\_\_\_

**APPROVED BY** \_\_\_\_\_ **DATE** \_\_\_\_\_