Lions SightFirst Foundation of Southern Nevada

FINANCIAL APPLICATION FORM

Application for: ❑ Self ❑ Child/Dependant

If filling out information for a child applicant, please use parental information for financial data, and child's information for the medical data

Application Fee: There is a $20.00 fee for processing this application. The fee is non-refundable. Please make checks out to Lions SightFirst Foundation. Cash can be stapled to the form and returned to a participating office, or mailed.

Name of Person Seeking Eye Care: _____Date of Birth: _____

Social Security Number: _____

Name of Parent or Guardian (if applicant is a minor): _____

Current Address: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Cell Phone: _____

Email Address: _____ Gender: Male Female

Who referred you to the Foundation? _____

Do you need… New glasses Eye Surgery Medical eye exam Other: _____

What is the main eye condition or problem you are having?

Have you been diagnosed with an eye disease by any eye care provider in the past? YES NO

If Yes – please describe…

Have you had any past eye surgeries? YES NO

If Yes – please describe…

When was your last eye exam? _____

What eye doctor did you see? _____

What did they tell you about your eyes? _____

Do you regularly use glasses for distance vision? YES NO

Do you regularly use glasses for near vision? YES NO

Do you see well with your current glasses? YES NO N/A

Are your current glasses in good working condition? YES NO N/A

Financial Information (of the patient if older than 18, of the parent or guardian if the patient is a child):

Marital Status? Married Single Divorced (name of spouse _____)

Please list all dependants in household (name and age)

Are you employed? YES NO

If YES, name of employer _____ work Phone _____

Monthly Salary: _____

Is your spouse employed? YES NO N/A

If YES, name of employer _____ work Phone _____

Monthly Salary: _____

Your Bank Name: _____ ❑ Checking ❑ Savings

Current bank balance: _____

Does anyone in the family have medical insurance coverage? YES NO

Does the applicant have health insurance coverage including Medicare or Medicaid? NO YES (company name:_____)

Have you ever served in the U.S. Military? YES NO

For questions about the Lions SightFirst Foundation or this application. Please email us at sightfirstlv@gmail.com. Or call at 702-347-2576.

Please check next to any other sources of income you may get each month…

❑ Disability (amount _____) ❑ Child Support (amount _____)

❑ Social Security (amount _____) ❑ Retirement/pension (amount_____)

❑ VA benefits (amount _____) ❑ Unemployment (amount _____)

❑ Alimony (amount _____)

Estimated total family monthly income: _____

You must provide documentation to verify your financial information. Acceptable written evidence must contain your name, amount of income received through that source, and the date.

If you have no bank accounts or income statements (paycheck stub for example) you must provide a short letter from someone knowledgeable about your living circumstances. This could include a social worker, religious or civic organization, or family member.

Required documents: ❑ Paycheck stubs (2 months) ❑ Bank Statements (2 months)

❑ Federal Tax forms (most recent year) ❑ Photo ID

ATTESTATION

I hereby attest that all of the information entered on this form is accurate and true. I fully understand that the services requested are limited to individuals who qualify according to the Foundation's Income Eligibility Guidelines. I agree to release and discharge the Foundation and all persons rendering such services from any claims I may have arising from these services so rendered. This application and other documents may be shared with eye care professionals as deemed necessary by the Foundation. I also authorize the Foundation to make any investigation concerning me and my dependants which is necessary to establish eligibility for assistance. I agree to allow a summary of my eye history, care received through the foundation, and the outcomes of my treatment (or treatment of a dependant minor) to be shared with potential donors including testimonials, and photos, which could appear in published information such as our website, brochures, fundraising events, and other communication materials.

Signature: _____ Date: _____

I understand that this application will not be processed until the Foundation has received:

- Application completed in full
- Application fee
- Supporting documents as listed above

Initials: _____

Please return completed form:
fax (702) 946-5058
or mail
PO Box 371705
Las Vegas, Nevada 89137