



# WV LIONS APPLICATION for SIGHT or HEARING ASSISTANCE

Sponsoring Lions Club \_\_\_\_\_ Dist \_\_\_\_\_ Date \_\_\_\_\_  
 Lion member submitting \_\_\_\_\_ Phone \_\_\_\_\_  
 Assistance being requested \_\_\_\_\_  
 Referring doctor \_\_\_\_\_ Phone \_\_\_\_\_

**Complete and return this application to the Lion or Lions Club which made it available to you.**

Your answers to personal and private information will be important in determining your qualifications for assistance through the West Virginia Lions Sight Conservation Foundation (WVLSCF). If you fail to answer any of the questions, or don't give acceptable reasons why you did not answer, your application will be delayed or denied. Your answers and attached supporting information will be treated with the utmost confidence by Lions and the service providers with whom Lions work. If this application is approved, you will receive services from professional technicians, physicians, and medical facilities with whom Lions work. Individual Lions, Lions Clubs, the WVLSCF, and Lions Clubs International accepts no responsibility whatsoever for the accuracy or reliability of these services.

**By your signature on this application, you have read and agreed to the above terms.**

Applicant Name _____ Phone _____	<b>Income: Yearly</b>
Address _____	Veterans _____
City/State/Zip _____	Food Stamps _____
Social Security # _____ Sex ____ Date of Birth ____/____/____	Unemployment _____
SSI _____ Aid from other sources _____	Pension/Retirement _____
Applicant's employer/location _____	Social Security _____
Phone _____ Wages per month \$ _____ Years employed _____	Alimony _____
Reason for leaving _____	Child Support _____
Spouse's Name _____ Phone _____	Public Assistance _____
Employer _____ Wages per month \$ _____	Case # _____
Number of dependents living with you _____	Other _____
Name _____ Age _____ SS # _____	<b>Expenses: Yearly</b>
Name _____ Age _____ SS # _____	Gas _____
Name _____ Age _____ SS # _____	Electric _____
Total household income yearly \$ _____ total in checking/savings \$ _____	Water _____
Other assets _____	TV/Cable _____
Own your home? _____ Value \$ _____ Payments \$ _____	Telephone _____
Do you rent? _____ Monthly Rent \$ _____ Utilities Included _____	Real Estate Tax _____
List vehicle(s): year, model _____	Property Tax _____
Value: \$ _____ Payments \$ _____ Insurance \$ _____	Life Insurance _____
	Auto Insurance _____
	Supplemental Insurance _____
	Prescription _____
	Other _____

Applicant's Signature \_\_\_\_\_ Date \_\_\_\_\_  
 Parent/Guardian Signature \_\_\_\_\_ Date \_\_\_\_\_

### REPORT OF SIGHT FOUNDATION SERVICE COORDINATOR

\_\_\_\_\_  
 Signature \_\_\_\_\_ Phone \_\_\_\_\_ Date \_\_\_\_\_  
 Approved  Disapproved

**SEE BACK OF PAGE FOR GUIDELINES**