DISTRICT OH5 EYE CARE FUND
INDIVIDUAL GRANT APPLICATION

DATE: _____

APPLICANT or LIONS CLUB NAME: _____

If Lions Club list name and Email address of contact Lion:

Name: _____ **Email:** _____

FOR WHOM ARE YOU REQUESTING THIS FUNDING: _____

APPLICANTS CONTACT PHONE NUMBERS: ***(Please submit two numbers, if possible)***

_____

APPLICANTS EMAIL ADDRESS: _____

APPLICANTS MAILING ADDRESS: _____

_____

_____

IF YOU ARE REQUESTING FUNDS FOR ANOTHER PERSON, PLEASE COMPLETE THE FOLLOWING QUESTIONS.

NAME OF RECIPIENT(S): _____

RECIPIENT PHONE NUMBER: _____

RECIPIENT EMAIL: _____

RECIPIENT MAILING ADDRESS: _____

_____

_____

TOTAL AMOUNT OF MONEY ARE YOU REQUESTING FROM THE DISTRICT OH 5 EYE CARE FUND:

_____

PLEASE DESCRIBE HOW THIS MONEY WILL BE USED: (List Name, Address of the Service Provider/s and The Dollar Amounts for each):
(Please be aware that the District OH 5 Eye Care Fund Disbursements can be made only directly to the Service or Medical Provider.)

	Provider Name	Providers Address	Amount
(1)			$
(2)			$
(3)			$
(4)			$
(5)			$

IS ANY PART OF THIS REQUEST COVERED BY INSURANCE, MEDICARE/MEDICADE OR ANOTHER SOURCE? (Please list)

_____

_____

_____

HAVE YOU REQUESTED OR RECEIVED FUNDING FROM ANY OTHER SOURCE(S)? (Please List)

_____

_____

_____

LIST ANY PAST FUNDING HISTORY FROM THE DISTRICT 13-F EYE CARE FUND: (*Year & Amount, Past Five Years)*

_____

_____

PLEASE PROVIDE MEDICAL DOCUMENTATION, SPECIAL ED LETTER, DOCUMENT OF ALL DIAGNOSIS AND/OR REQUIREMENT FOR THERAPY.

☐ **MEDICAL DOCUMENTATION IS ATTACHED**

PLEASE COMPLETE THE FINANCIAL DATA FORM ON FOLLOWING PAGE FOR ALL WAGE EARNERS IN THE HOUSEHOLD OF THE PERSON RECEIVING FUNDS

FINANCIAL DATA: Income tax figures from a complete and filed tax return(s) for the prior year.
(PLEASE REDACT ALL SOCIAL SECURITY NUMBERS)

HOUSEHOLD INCOME, FEDERAL TAX AND ASSETS (include all if filing separately.):

Income	**Adjust Gross Income (Line 31 of Prior Year 1040)**	**$** _____
	Non Taxable Income (Soc. Sec., Child Support, AFDC, etc.)	**$** _____
	Total U.S. Federal Tax Paid in Tax Year	**$** _____
Assets	**Cash, Savings, Checking accounts, Investments**	**$** _____
	Home, if owned: Assessed Value	**$** _____
	Current Mortgage Balance	**$** _____
Medical Expenses (not covered by insurance)		**$** _____

How many dependent children in the household and their ages:

Number _____ **Ages** _____

Explain below any unusual circumstances in the household that affect the family's finances
(Illness, elderly dependent family member, etc. Please attach any supportive documentation)

_____

_____

I certify that the information provided is complete and accurate to the best of my knowledge. If requested, I agree to provide verification of the information I have given on this form, including a copy of my U.S. Income Tax Return. Falsification of information may result in termination of any funding granted by the District OH 5 Eye Care Fund.

Signature: _____ Date: _____

Requestor Instructions: *The District OH 5 Eye Care Fund funding process involves two separate group reviews and can take from six weeks up to three months. To expedite the process please ensure that this application is received prior to the first day of each month.*

District OH 5 Eye Care Fund Advisory Committee,
Ben Cosgray, Chairman
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District Governor Mike Kerek
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