WEST TEXAS LIONS EYE HEALTH FOUNDATION, INC.,

ASSISTANCE APPLICATION

THIS FORM MUST BE SUBMITTED THROUGH AN
INTERNATIONAL ASSOCIATION OF LIONS CLUBS
AFFILIATE CLUB

Name of recipient:	Telephone: Home: ( ) Office: ( )	Date:
Residence Address: Street:	City:	State: Zip Code:
Name of requester: (if different from recipient)	Relationship of requester to recipient:	Date of Birth of Recipient

Nature of request:

☐ Financial Assistance ☐ Information ☐ Other

Describe request:

Please complete this section if requesting financial assistance:

Is the recipient covered by: ☐ MEDICARE ? ☐ MEDICAID ? ☐ OTHER _____ ☐ NO MEDICAL INSURANCE

Family profile: ☐ Husband / Wife ☐ Single Parent Household

Number of dependent children living in household: ____

Number of other dependents living in household: ____

MONTHLY FAMILY INCOME/EXPENSES FROM ALL SOURCES

INCOME		EXPENSES	
Wages, salaries & tips	$	Rent / Mortgage *	$
Unemployment Compensation	$	Utilities	$
Social Security Compensation	$	Food	$
Child Support	$	Clothing	$
Aid to Dependent Children	$	Telephone	$
Food Stamps	$	Car Expenses	$
Pensions and Annuities	$	Car Insurance	$
Alimony	$	Alimony	$
Earned Income Credit	$	Child Support	$
Workman's Compensation	$	Medical	$
Other	$	Other	$
Total Monthly Income	$	Total Monthly Expenses	$

** If you are receiving free or subsidized rent assistance, please list amount and source:* _____

MEDICAL PROCEDURE DETAILS

Consulting physician or other service provider: _____

Total cost of medical procedure: $ ____ Amount available from other sources: $ ____

Medical Insurance Coverage: $ ____ Amount requested from West Texas Lions Eye Health Foundation: $ ____

I certify that all information on this application is true and complete to the best of my knowledge and I agree to provide additional documentation to verify need if requested. I agree to inform the sponsoring Lions Club immediately of any changes in my income or family size. I understand that giving any false information could jeopardize approval of this application.

Signature of Applicant: _____ Date Signed _____

WTLEHF FORM 0001-2000 (07/00 - REV 10/11)

A COPY OF THIS APPLICATION, COMPLETE WITH ALL ENDORSEMENTS WILL BE PROVIDED TO THE WEST TEXAS LIONS EYE HEALTH FOUNDATION, INC. PRESIDENT AND TREASURER

ENDORSEMENTS AND FINAL DISPOSITION

SPONSORING LIONS CLUB

Name of Club _____ **Lions Club**

District _____ **City** _____ **State or Country** _____

Recommendation: ☐ **Financial Assistance** → **Amount Requested** $ _____ ☐ **Other Assistance**

Club Participation ☐ **Financial Assistance** → **Approved Amount** $ _____ ☐ **Other Assistance**

Remarks: _____

_____

_____

_____

Date: _____ **Signature** _____

Lions Club President

SCREENING COMMITTEE ENDORSEMENT

Recommendation: ☐ **Financial Assistance** → **Amount Recommended** $ _____ ☐ **Other Assistance**

Contingent upon:

Club Participation: ☐ **Financial Assistance** → **Amount Recommended** $ _____ ☐ **Other Assistance**

Other (explain in remarks): ☐ **Financial Assistance** → **Amount Recommended** $ _____ ☐ **Other Assistance**

Remarks: _____

_____

_____

_____

Date: _____ **Signature** _____

Chairman, Screening Committee

BOARD OF TRUSTEES

Approval: ☐ **Financial Assistance** → **Amount Approved** $ _____ ☐ **Other Assistance**

Contingent upon:

Club Participation: ☐ **Financial Assistance** → **Amount Required** $ _____ ☐ **Other Assistance**

Other (explain in remarks): ☐ **Financial Assistance** → **Amount Required** $ _____ ☐ **Other Assistance**

Remarks: _____

_____

_____

_____

Date: _____ **Signature** _____

Chairman, Board of Trustees

INSTRUCTIONS: ***<u>This form must be endorsed by an active Lions Club</u>***

1. Complete the entire form.
2. Under "**Describe request**" please indicate the procedure to be performed and any attempts to obtain help from other agencies (i.e. Medicare, Texas Commission for the Blind, Lighthouse for The Blind, etc.)
3. Under "**MEDICAL PROCEDURE DETAILS**" provide all pertinent information indicated on the form and attach estimated charges signed by attending physicians and/or other facilities or medical participants as appropriate.

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