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: ( ) email:	Today's Date:
Residence Address: Street:	City: State:	Zip Code:
Name of requester: (if different from recipient)	Relationship of requester to recipient:	Your Date of Birth

Nature of request:

☐ Financial Assistance   Do you have an SS#? Yes or No *(Please Circle One)*   Are you employed? Yes or No *(Please Circle One)*

Describe request: ____________________

Please complete this section if requesting financial assistance:

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

Family profile: ☐ Married ☐ Single Parent Household ☐ Widow/Widower

Number of dependent children living in household: ☐   Number of other dependents living in household: ☐

MONTHLY FAMILY INCOME/EXPENSES FROM ALL SOURCES

INCOME		EXPENSES		MEDICAL PROCEDURE DETAILS	
Wages, salaries & tips	$	Rent / Mortgage *	$	Total Cost	$
Unemployment Compensation	$	Utilities	$	Medical Insurance Cov.	$
Social Security Compensation	$	Food	$	Other/Explain	$
Child Support	$	Clothing	$		$
Aid to Dependent Children	$	Telephone	$		$
Food Stamps	$	Car Expenses	$		$
Pensions and Annuities	$	Car Insurance	$		$
Workman's Compensation	$	Child Support	$		$
Other/Explain	$	Medical	$		$
Total Monthly Income	$	Other	$		$
		Total Monthly Expenses	$		$
				Total Med. Procedures	$

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

MEDICAL PROCEDURE DETAILS

Attending physician or other Service Provider: (Name & Phone) ____________________

Do you have medical eye exam results results? Please attach to application

Amount available from other sources: $ ______   Can you or your family contribute towards this cause: $ ______

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 03/16)

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

Return to: Frank Ramirez, 842 Southwick Dr., El Paso, TX 79928, Fax: (915) 544-0214, or email: LionFrankR@gmail.com
or Susan Driscoll, 513 Mallory Ct., El Paso, TX 79912 or email: sue_billdriscoll@earthlink.net