APPLICATION FOR VISUAL AID // HEARING ASSISTANCE
GRANTS PASS LIONS CLUB

Request for: Vision exam-____ Glasses-____ OR Hearing Test- ___ Hearing Aid ___

Applicant Name________________________________ Age____ Date of Birth__________

Social Security Number________________ Parent/Guardian Name________________________

Address_____________________________ City________________ Zip Code_____________

Mailing address (if different)____

Home Phone________________________ Work/Message/Cell Phone__________________

NOTE: OUR VOLUNTEERS MUST BE ABLE TO REACH YOU BY PHONE

How long a permanent resident of Josephine/Jackson County____________________

Occupation (if minor, parent/guardian occupation)________________ Employer_______________

All Others in household:

Name	Age	Name	Age

Insurance information: Company ______________________ Policy #_________________None ___

Rave you received assistance from Lions before? Y N If yes, when?___________________

Household Monthly Gross Income:		**Household Monthly Expenses:**	
Combined wages, all jobs		Rent/Mortgage	
Child support/alimony		Utilities	
Food Stamps		Food	
Social Security		Child Care	
Retirement/ Pension		Car/Transportation	
Disability Benefits		Medical	
Unemployment		Credit Cards	
Other Income (list)		Other Expenses	
		list	
Total Income:		Total Expenses:	

How much can you pay towards your exam, glasses or haring aid? ___________________

Comments:

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Applicant Signature (parent/guardian if minor) ______________________________ Date ____________

Completely fill out and return to: Grants Pass Lions Club, P.O. Box 6, Grants Pass, OR 97528

NOTE: incomplete applications may not be accepted. You are responsible to notify us ASAP if any information changes if you want to be considered for :assistance

FORMCORM VERSION "7.06

Applicant must Read and Sign this Statement

I fully understand these services are limited to individuals unable to pay for or receive hearing aids or glasses from other sources of assistance. In consideration of these services, I release and discharge all persons rendering such services from any claims I may have arising from services so rendered. I am aware that any amount billed to me prior to the approval of this application will not be paid for by this service.

I also understand my application may be reviewed by the Lions Club and other care professionals. These forms will be kept on file by the Lions Sight & Hearing Center, the care professional, and possibly. LCIF. The documents will be kept confidential and not shared with third parties, such as insurance companies.

All information on and attached to this application is true and correct to the best of my knowledge.

____
Applicant's Signature

____
Witness (If applicant signs with an "X")

____
Parent Guardian Signature if person is under 13)

For Office Use Only Assigned to ______________________________ Date __________________