LIONS SIGHT & HEARING FOUNDATION OF SOUTHERN CALIFORNIA

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APPLICANT INFORMATION FORM

Date: ______________________

The Lions Sight & Hearing Foundation of SC (LSHFSC) has not granted any authority, expressed or implied, to any person, organization or governmental agency, including, but not limited to, any person, referral organization. Lion Club or physician from whom you may have obtained this referral for, to act on behalf of or to otherwise bind the LSHFSC in any manner whatsoever. Neither this application form nor your receipt of this application form from any such source is a representation from the LSHFSC of any authority actual or apparent, in such source and all such expressions of authority are hereby disclaimed. You should direct any questions regarding the services available through the LSHFSC eligibility for such service, the cost of such services and this Referral Form directly to the LSHFSC offices at the address and or phone number set forth above. There is no application fee associated with the submittal to and review by the LSHFSC of this referral form.

Applicant: Miss, Mrs., Ms., Mr. (circle one)

Name: ____ Sex: M F Home Phone: ( ) _________________________

Home Address: ____ City: __________________________ Zip Code: ___________

Date of Birth: __________________ Age: _________ Social Security #: _______________________Citizenship: ________________

Occupation: ______________________________ Employer______________________________ Phone ( ) ___________________

Business Address: ___________________________________ City: _________________________ State: ____ Zip Code: _________

Contact Person: ____________________________ Relationship: _______________________ Phone: ( ) _____________________

Total number of persons in household: Adults: ___________ Children: ___________ Ages of Children: _____________________

Best Day and Time to Call Applicant: ______________________

MONTHLY BUDGET: This is the monthly income and expense of the household.

1. Income: Husband_________________ Wife________________ Child Support _____________________Other_______________

Other Income (e.g. SSI, SS, Food Stamps, ADC, Interest, Dividends. Royalties, etc).

TOTAL MONTHLY INCOME **$____________________**

2. Monthly Expenses (approximate amounts)

Rent and Mortgage payment	$____________________
Utilities (Phone, Gas, Water, etc)	$____________________
Groceries	$____________________
Insurance (Auto, Health, Life, Property, etc)	$____________________
Installment Payments (Indicate date of final payment)	
Auto (date) ___________________	$____________________
Loan (date) ____________________	$____________________
Charge Cards (date) _______________	$____________________
Other Monthly Expenses	
Child Support	$____________________
Medical	$____________________

TOTAL MONTHLY EXPENSE **$____________________**

Please include any unusual and extraordinary expenses on a separate sheet

IMPORTANT: Please enclose the first two (2) pages of last year's income tax return. If not required to file, attach copy of proof of income (W-2, Check pay stubs, etc.)

LSH File #:______________________

Applicant Information Form cont'd

Amount you can pay towards this need: $ ________________

Has a specific source guaranteed ANY payment towards this need? Yes _____ No ______

If "Yes" Name of Organization: ______________________________ Amount $ ________________________

Contact Person: _______________________________________ Phone #: ( ) _________________________

Insurance, (Medical, Medicare, Other (Specify) ____

Have you seen a doctor concerning your particular need? Yes ______ No ______

If "Yes" Name of Doctor: _______________________________ Phone #: _____________________________
(Include copies of any information which you may have concerning your need) Diagnosis:

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FOR APPLICANTS WHO ARE UNDER 18 YEARS OLD:
Any Applicant under 18 years old MUST have an authorization before being accepted. Responsible person please read and sign below.

I am aware of this request for assistance from the LSHFSC and am willing to accept the services as provided by them for this minor child.

Signature: ____ Social Security: _____________________

Relationship to Applicant: ____

Sight Applicants: Those affected by **diabetes MUST** have a note from the attending physician regarding the status of the disease **before** any surgical procedure is done.

Please describe visual/hearing problem: ____

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Physician, Eye Specialist, Audiologist or Dispenser:

Name: ______________________________ Phone #: ( )______________ Email: ____________________

Address: ____ Suite #: __________________

City: ____ State: _____ Zip Code: _______________

LSH File #:_____________________

Applicant Information Form cont'd

RELEASE: I for myself, my heirs, personal representatives, executors, administrators and assigns, and on behalf of the patent if the Applicant is other than myself and I am the responsible party for the Applicant, waive, release and forever discharge the LSHFSC and California Lions Clubs, their officers, directors, agents, representatives, successors and all cooperating entities and individuals from any and all claims, losses, damages, or death, which now exist or may hereafter arise in connection with my and/or the Applicant's participation with or any service rendered through the LSHFSC. To the best of my knowledge, I represent and warrant the above information to be correct. **RELEASE OF INFORMATION:** I authorize any service provider to whom I am referred by LSHFSC and to the Lions Club to release to the LSHSC any information required, including recommended course of treatment, service performed, and any recommended follow-up. False statements are grounds for refusal of benefits.

Signature: ____ Date: ____________________________________

Print name:____

FOR LIONS OFFICE USE ONLY:

Investigation /Referral by Lion: _____________________________________ Date: ___________ Phone #: (   ) _______________

Lions Club: ____________________Address:________________________ City: _______________ State: ___ Zip Code: _______

Approved: _____________________ Referred to: _______________________ Rejected: ________________________________

FOR LSH OFFICE USE ONLY:

Date Received: _______________________ Date to Committee: _____________________

LSH File #:______________________