APPLICATION FOR FINANCIAL ASSISTANCE FOR EYEGLASSES

PLEASE PRINT AND COMPLETE AS APPLICABLE PAGE 1 AND PAGE 2 IN FULL

AGENCY REFERRING	PERSON REFERRING	PHONE NUMBER	EMAIL OF PERSON REFERRING

APPLICANT'S NAME (Parent/Guardian if applying for child)			DATE OF BIRTH
CHILD'S NAME (If application is for a child.)			CHILD'S DATE OF BIRTH
ADDRESS	CITY/TOWN/STATE	ZIP	HOME PHONE
Email (Optional for faster processing)			MONTHLY RENT OR MORTGAGE PAYMENT
NAMES AND AGES OF DEPENDENT CHILDREN IN HOME			
EMPLOYER	MONTHLY INCOME		POSITION AND DUTIES

PLEASE LET US KNOW IF YOU OR OTHERS LIVING IN YOUR HOUSEHOLD RECEIVE INCOME FROM ANY OF THE FOLLOWING SOURCES. PARTICIPATION IN ANY OF THESE PROGRAMS CAN HELP VALIDATE YOUR NEED FOR OUR FINANCIAL ASSISTANCE.

SSI OR SSDI YES / NO (CIRCLE ONE)	AMOUNT	FOOD STAMPS YES / NO (CIRCLE ONE)	AMOUNT
SOCIAL SECURITY YES / NO (CIRCLE ONE)	AMOUNT	WELFARE YES / NO (CIRCLE ONE)	AMOUNT
VA DISABILITY YES / NO (CIRCLE ONE)	AMOUNT	OTHER (LIST)	AMOUNT

ARE YOU RECEIVING MEDICAL CARE THROUGH MEDICAID?
IF "YES' IS YOUR MEDICAID CARE ORGANIZATION **NH Healthy Families, WellSense or AmeriHealth Caritas**? (CIRCLE ONE)

ARE YOU OR THE CHILD RECEIVING ASSISTANCE FROM ANY AGENCY FOR EYE CARE? YES / NO
AGENCY NAME

CONSENT AND RELEASE:

I consent to and permit any authorized representative of the Keene Lions Foundation to obtain necessary information from any person, employer, or agency concerning my financial or medical status relevant to this application. The Keene Lions Foundation will protect this information against any unauthorized disclosure.

I authorize the Keene Lions Foundation to provide this information to other Lions clubs to determine my eligibility for like assistance from them. I release the above-mentioned person, employer, or agency from any and all liability for damages from any inadvertent release of information on me or child. A copy of this consent and release will be as effective as the original and will be effective for six months from the date it was signed.

Applicant's Signature: _____ Date _____

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PLEASE USE THE SPACE BELOW TO LIST MONTHLY OBLIGATIONS WHICH MAKE IT UNAFFORDABLE FOR YOU TO PAY FOR YOUR EYESIGHT CARE. EXAMPLES MIGHT BE SUPPORT, CHILD CARE, LOAN PAYMENTS, MEDICAL COSTS OR OTHER.

_____PAYMENT $ _____

_____PAYMENT $ _____

_____PAYMENT $ _____

_____PAYMENT $ _____

_____PAYMENT $ _____

_____PAYMENT $ _____

_____PAYMENT $ _____

_____PAYMENT $ _____

TOTAL

WHAT ASSISTANCE DO YOU NEED?

EYE EXAM	YES / NO	NAME OF EYE DOCTOR AND OFFICE
FRAME	YES / NO	YOU WISH TO SEE?
LENSES	YES / NO	

_____

CHECK BOX IF NO PREFERENCE ☐

PLEASE DESCRIBE IN DETAIL WHY YOU NEED ASSISTANCE FROM KEENE LIONS FOUNDATION:

_____

_____

_____

_____

_____

Mail this completed form to:

Keene Lions Foundation, Inc.
Eyesight and Hearing Committee,
PO Box 62,
Keene NH 03431-0062

Optionally, you may sign, scan and email the application to keenelions@gmail.com