APPLICATION FOR FINANCIAL ASSISTANCE FOR EYEGLASSES

PLEASE PRINT AND COMPLETE IN FULL

MAIL TO: KEENE LIONS CLUB EYESIGHT AND HEARING COMMITTEE
PO BOX 62, KEENE NH 03431-0062

Optionally sign, scan and email to:
KeeneLions@gmail.com

AGENCY REFERRING	PERSON REFERRING	PHONE NUMBER	EMAIL

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	ADDRESS	PHONE

MONTHLY INCOME	POSITION AND DUTIES

DO YOU THE APPLICANT AND/OR CHILD RECEIVE INCOME FROM ANY OF THE FOLLOWING SOURCES?

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

IF UNEMPLOYED, DO YOU RECEIVE UNEMPLOYMENT COMPENSATION? YES / NO (CIRCLE ONE) ARE YOU ACTIVELY SEEKING EMPLOYMENT THROUGH THE UNEMPLOYMENT OFFICE? YES / NO	AMOUNT

DOES ANYONE IN YOUR FAMILY RECEIVE INCOME FROM ANY OF THE FOLLOWING SOURCES?
PLEASE LIST THEIR NAME AND RELATIONSHIP BELOW.

SSI OR SSDI NAME	AMOUNT	FOOD STAMPS NAME	AMOUNT
SOCIAL SECURITY NAME	AMOUNT	WELFARE NAME	AMOUNT
VA DISABILITY NAME	AMOUNT	UNEMPLOYMENT COMPENSATION NAME	AMOUNT

HAVE YOU OR ARE YOU RECEIVING ASSISTANCE FROM ANY AGENCY FOR EYE CARE OR HEARING? YES / NO

AGENCY NAME	DATE

ARE YOU RECEIVING MEDICAL CARE THROUGH MEDICAID? YES / NO (CIRCLE ONE)
IF "YES' IS YOUR MEDICAID CARE ORGANIZAION NH HEALTHY FAMILIES, OR WELL SENSE? (CIRCLE ONE)

PLEASE COMPLETE BOTH PAGE 1 AND PAGE 2 OF THIS APPLICATION

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 $ ________

TOTAL

WHAT ASSISTANCE DO YOU NEED?	EYE EXAM	YES / NO	NAME OF EYE DOCTOR AND OFFICE YOU WISH TO SEE?
	FRAME	YES / NO	________________
	LENSES	YES / NO	CHECK BOX IF NO PREFERENCE ☐

REMARKS: YOU MUST DESCRIBE IN DETAIL WHY YOU NEED ASSISTANCE FROM KEENE LIONS CLUB:

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AUTHORIZATION AND RELEASE

This authorization and release constitutes my consent to disclosure of any relevant or necessary information or records to any duly authorized official of Keene Lions Club by any person, corporation, agency or association concerning my character, employment, financial status, debts, income, financial assistance or medical status for determination of my eligibility for financial assistance by Keene Lions Club. This authorization includes, but is not limited to, banks or other financial institutions, present and former employers, the State of New Hampshire Department of Employment Security, Social Security Administration, Department of Welfare, Food Stamps Program, Veterans Administration, Workman's Compensation and Medical organizations.

This authorization is executed with full knowledge and understanding that Keene Lions Club will take measures to protect the aforementioned information against unauthorized disclosure to any parties not having a legitimate need for it. As deemed appropriate by officials of Keene Lions Club, I authorize that this information be provided to other Lions clubs in order to determine my eligibility for assistance from them. I hereby release the aforementioned persons, corporations, agencies, associations, organizations and their employees, agents and representatives from any and all liability for damages resulting from inadvertent release of information or from a decision by Keene Lions Club not to financially assist me on account of compliance or any attempts at compliance with this authorization except for any damages resulting from knowingly providing false or misleading information or records on me.

A copy of this authorization shall be as effective and valid as the original. This authorization shall be effective for six months from the date it is signed.

Applicant's Signature: ______________________ Date ________________

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