## MANCHESTER LIONS CLUB APPLICATION FOR EYECARE AID

## IF YOU DO NOT SPEAK ENGLISH YOU MUST PROVIDE AN INTERPRETER!

All questions <u>MUST</u> be answered if this application is to be considered. Information revealed herein will be kept strictly confidential and will be used solely for the evaluation of you request for financial assistance. <u>NO</u> professional treatment will be paid for by the Lions Club unless expressly authorized in writing by our President or designated member. **THIS IS A ONE TIME ASSISTANCE PROGRAM.** 

	APPLICANTFirst Name					
			Middle Initial		t Name	
	1A. SOCIAL SECURITY NUME	BER <del></del>	<b></b>	Date o	f Birth	
	REFERRED BY:			TODAY	''S DATE	
3.	CURRENT ADDRESS					
۰.	Street		City	Z	ip Code	Number of years there
ЗA.	PREVIOUS ADDRESSStreet		City		ip Code	Number of years then
SO The fror Yes	INDICATE WHETHER APPLICAN URCES: e Lions are able to help only those on the following, please call them are s/No  SCHOOL CHILDREN from kind INCOME ASSISTANCE from are PERMANENTLY DISABLED index SENIOR CITIZENS age 65 or ole TANF recipients*  MEDICAID COVERAGE* please UNITED STATES VETERAN  e-care is provided by Medicaid (if the ASON:	who have no one else and ask. If they indicated dergarten to graduate anywhere ividuals* der* or having Medicated list card numberese individuals are fi	se to turn to for ate you're not element of 12 yearsHe are coverage/ple	eye-care aid. ligible, please althy Kids Prograse list card nur Spend of	If you're indicate to ram or other	THE FOLLOWING e not sure of eligibilit he reason below. er source.  unt of Human Services
5.	PHONE NUMBER WHERE YOU CAN	BE REACHED		TIME TO	CALL	
6.	EMPLOYER			_OCCUPATION	l	
	DATE HIRED NET	INCOME	/MONTHLY	DATE LEFT		
c۸	DDEVIOUS EMPLOYED			OCCUPATION		
	PREVIOUS EMPLOYER					
D	DATE HIRED NET	INCOME	/MONTHLY	DATE LEFT		
1 2 7 1 1	OTHER INCOME: Pension Investments Social Security Workmen's Compensation Unemployment Compensation NH Welfare TANF (Temp. Aid for Needy Families) Other	DATE STARTED	DATE E	NDED	AMOUN	T / MONTHLY
8.	PLEASE COMPLETE THE FOLLOWIN Name	NG FOR ALL INDIVIDI Relation		ITH APPLICAN Age		lonthly Income

9. Child Support:	(monthly) Alimony:	(monthly)	VA Disability:	(monthly)
Total value of : Check	ing and Savings accounts \$_	Inv	estments \$	
	Make Make		oan Payment _ oan Payment _ Current va	Monthly  Monthly lue \$
Heat & Electric	gage paymentmonthly Am	monthly AND/OR / ount of fuel assistance receivenly Recurring medical ex	ved	
11. HAVE YOU PREVIOU	SLY APPLIED TO A LIONS	OOD ASSISTANCE OF ANY CLUB FOR EYE-CARE AID?		_YEAR?
14. Date of last eye e		Doctors Name:		
17. I, the APPLICAN organization to r statements mad MANCHESTER ALSO UNDERS	NT, certify that this applica release to the MANCHEST e in this application. In co LIONS CLUBS OF NH ha	tion is accurate and comp FER LIONS CLUBS OF NI Insideration of any aid, wh Irmless from any injury res ENO EXPRESSED OR IN	lete. I hereby H any informat ich may be gra sulting from tre	anted, I agree to hold the eatment paid by them. I
Applicant's Signature				
CLUB CONTACT	NAME	PHON	NE NO.	DATE