

NOTICE: THIS IS A (2) PAGE APPLICATION TO BE COMPLETED BY YOU.
ALL PAGES MUST BE COMPLETED BEFORE PROCESSING!!!
INCOMPLETE APPLICATIONS WILL NOT BE RETURNED FOR COMPLETION!!!



Central City Lions Club
Post Office Box 1129
Centralia, Illinois 62801



REQUEST FOR ASSISTANCE
FOR EYE EXAM AND/OR EYEGLASSES
OR HEARING AIDS.

**BEFORE FILLING OUT THIS APPLICATION: IF YOU ARE ON A
DEPT. OF HUMAN SERVICES MEDICAL CARD, YOU DO NOT
QUALIFY FOR OUR ASSISTANCE PROGRAM.**

IF REFERRING AGENCY: PLEASE LIST AGENCY NAME, CONTACT PERSON AND TELEPHONE NUMBER:

Applicant Information: PLEASE PRINT

Name _____ Date _____
Last First Middle
Address _____ Phone _____
Street Apt. Number Home
City _____ State _____ Zip _____
Phone _____ Male _____ Female _____
Work or Cell
Date of Birth _____ Social Security # _____

Assistance Requested: Exam Eye _____ Eye Glasses _____ Hearing _____

**** If the applicant is less than 18 years of age, a parent or guardian must complete the rest of the application.
If minor, names of parent(s) or guardian(s): Circle one that relates to you..**

Name _____ Date _____
Last First Middle
Address _____ Phone _____
Street Apt. Number Home
City _____ State _____ Zip _____
Phone _____ Male _____ Female _____
Work or Cell
Date of Birth _____ Social Security # _____



IMPORTANT TO COMPLETE PAGE 2 ON BACK

Marital Status _____ Number of Dependents _____ Ages _____

How many in the household contribute to the monthly household income: _____

Employment Status: Currently Employed _____ Occupation _____

Employer Name: _____

Address _____ Phone _____
Street

City _____ State _____ Zip _____

Are you disabled? _____ Nature of disability? _____

Student _____ Full time _____ Part Time _____

TOTAL MONTHLY HOUSEHOLD INCOME VERSUS EXPENSES

Wages or General Assistance	\$ _____	Rent/Mortgage	\$ _____
Pension	\$ _____	Utilities	\$ _____
Unemployment	\$ _____	Medical	\$ _____
Social Security/SSI	\$ _____	Clothing	\$ _____
Food Stamps	\$ _____	Food	\$ _____
Child Support	\$ _____	Daycare	\$ _____
Alimony	\$ _____	Automobile	\$ _____
Other	\$ _____	Other	\$ _____
Total	\$ _____	Total	\$ _____

INCOME VERIFICATION:

****PLEASE ATTACH A COPY OF YOUR CURRENT FEDERAL OR STATE TAX RETURN.****

Do you have medical insurance, if so: Public Aid _____ Yes _____ No _____

Insurance Carrier: _____

Insurance Carrier Contact: _____

Can you share in costs? Yes _____ Name _____ Phone Number _____
How Much? _____ No _____

Have you applied for Social Security Disability? Yes _____ If yes, when _____

If denied, have you re-applied? _____

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JUST A REMINDER!!!!!!

To verify income, please attach a copy of
most recent **FEDERAL** or **STATE 1040 INCOME TAX RETURN**
or your **SI/SSD ANNUAL COST OF LIVING INCREASE DOCUMENT**.
****Some form of proof of income is required.****

One of the above mentioned MUST BE ENCLOSED WITH This Application for processing.

**ANY OTHER USEFULL INFORMATION MAY BE WRITTEN
ON THE BACK OF THIS PAGE.**

AUTHORIZATION STATEMENT

(MUST be signed for consideration by the Lions Club Eyeglass/Hearing Aid Committee)

I, (X) _____ personally authorize the Lions Club to contact any
(your signature)
of the above stated Agencies or Employers for confidential verification.