Mail to:
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Lions MD 44 Health Services of New Hampshire Application (HSNH)
For Eyecare Aid

All questions **MUST** 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.

1. APPLICANT _____
First Name Middle Initial Last Name

Date of Birth _____ _____ _____ _____

2. REFERRED BY: TODAY'S DATE

3. CURRENT ADDRESS _____ _____ _____
Street City Zip Code Number of years there

PREVIOUS _____ _____ _____
Street City Zip Code Number of years there

4. INDICATE WHETHER APPLICANT IS ALREADY ELIGIBLE FOR EYE CARE PRESCRIPTION AID FROM

THE FOLLOWINGSOURCE:

The Sight & Hearing Foundation is able to help only those who have no one else to turn to for eye-care aid. If you are not sure of eligibility from the following, please call them and ask.
If they indicate you are not eligible, please indicate the reason below.

Yes/No
_____ SCHOOL CHILDREN from kindergarten to graduate of 12 years---Healthy Kids Program or other source.
_____ INCOME ASSISTANCE from anywhere
_____ PERMANENTLY DISABLED individuals*
_____ SENIOR CITIZENS age 65 or older* or having Medicare coverage/please list card number _____
_____ TANF recipients*
_____ MEDICAID COVERAGE* please list card number _____
_____ UNITED STATES VETERAN

***Eye-care is provided by Medicaid (if these individuals are financially needy) thru the NH Division of Human Services**
Eye Care Need::

_____

0. HOMEPHONE CELL EMAIL

1. EMPLOYER _____ OCCUPATION _____
DATE HIRED _____ NET INCOME _____/MONTHLY DATE LEFT _____

6A. PREVIOUS EMPLOYER _____ OCCUPATION _____
DATE HIRED _____ NET INCOME _____/MONTHLY DATE LEFT _____

2. OTHERINCOME: DATESTARTED DATEENDED AMOUNT/ MONTHLY
Pension
Investments
Social Security
Workmen's Compensation
Unemployment Compensation
NH Welfare
TANF (Temp. Aid for Needy Families)
Other _____

Total _____

8. PLEASE COMPLETE THE FOLLOWING FOR ALL INDIVIDUALS LIVING WITH APPLICANT:

Name	Relationship	Age	Monthly Income

9. Child Support :_____ (monthly) Alimony: _____ (monthly) VA Disability: _____(monthly)

Total value of: Checking and Savings accounts $ _____ Investments $

Car 1 _____ _____ Amount of Loan Payment _____
Year **Make** **Monthly**

Car 2 _____ _____ Amount of Loan Payment _____
Year **Make** **Monthly**

Real estate owned: Description _____Current value $ _____

3. HOUSEHOLD EXPENSES THAT **YOU PAY**:

Apartment rent/Mortgage payment _____monthly AND/OR Amount paid by Section 8 pays _____

Heat & Electric _____monthly Amount of fuel assistance received_____

Food allowance received _____ monthly Recurring medical expenses _____ monthly

List other expenses: _____

10A. ARE YOU RECEIVING HEAT, HOUSING OR FOOD ASSISTANCE OF ANY KIND? ___ MONTHLY AMOUNT ____

4. HAVE YOU PREVIOUSLY APPLIED TO A LIONS CLUB FOR EYE-CARE AID?_____ YEAR? _____

5. WHAT EYE PROBLEMS ARE YOU EXPERIENCING?

_____

6. YES or NO, do you need:_____LENSES _____ FRAMES _ EXAM

0. Date of last eye exam: _____Doctors Name:_____
Address:_____

7. ADDITIONAL INFORMATION (IF NECESSARY) THAT WOULD HELP DEMONSTRATE FINANCIAL NEED:

_____

16., the APPLICANT, certify that this application is accurate and complete. I hereby authorize any individual or organization to release to the NH Sight & Hearing any information necessary to confirm statements made in this application. In consideration of any aid, which may be granted, I agree to hold the LIONS CLUBS OF NH harmless from any injury resulting from treatment paid by them. I ALSO UNDERSTAND THAT THERE ARE NO EXPRESSED OR IMPLIED SERVICES OTHER THAN POSSIBLY +AN EXAM AND GLASSES.

Applicant's Signature _____ DATE