Mail to:
Terri McGrew
11 Rock Ramond Road
Brookline, NH 03033
terrimcgrew@charter.net

LIONS SIGHT & HEARING FOUNDATION APPLICATION
(NHLSHF)
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

SOCIAL SECURITY NUMBER _____--_____--_____ Date of Birth_____

2. REFERRED BY: _____ TODAY'S DATE_____

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

PREVIOUS ADDRESS_____ _____ _____ _____
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**
REASON:
_____

5. HOME PHONE_____CELL_____EMAIL_____

6. EMPLOYER_____OCCUPATION_____
DATE HIRED_____ NET INCOME_____/MONTHLY DATE LEFT_____

6A. PREVIOUS EMPLOYER_____OCCUPATION_____
DATE HIRED_____ NET INCOME_____/MONTHLY DATE LEFT_____

7. OTHER INCOME:	DATE STARTED	DATE ENDED	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 $_____

10. 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_____

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

12. WHAT EYE PROBLEMS ARE YOU EXPERIENCING? _____

_____

13. YES or NO, do you need: LENSES_____ FRAMES_____ EXAM_____

14. Date of last eye exam:_____ Doctors Name:_____
Address:_____

15. 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_____