

NAPLES LIONS CLUB REQUEST FOR ASSISTANCE FORM

Name _____ Birth Date _____ Age _____

Address _____ Email _____

City _____ State _____ Zip Code _____ Phone _____

Insurance: Name and policy number of any and all health insurance policies: _____

LIST NAMES AND AGES OF EVERYONE IN YOUR HOUSEHOLD

NAME	AGE	RELATIONSHIP
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_____	_____	_____
_____	_____	_____

MONTHLY HOUSEHOLD INCOME: \$ _____

MONTHLY HOUSEHOLD EXPENSES \$ _____

ASSISTANCE NEEDED FOR: EYE EXAM YES ___ NO ___ GLASSES YES ___ NO ___

EYE SURGERY YES ___ NO ___ If yes, for what type of Surgery _____

From which Eye Doctor _____ Location _____

APPLICANT MUST READ AND SIGN THIS STATEMENT: I fully understand that these services are limited to individuals unable to pay for and receive services from any other sources of assistance. In consideration of this assistance, I release and discharge any and all persons or organizations rendering such assistance from any claims I may have arising from services so rendered.

I also understand that my application may be reviewed by Lions Clubs and health professionals. These forms will be kept on file by local Lions and health care professionals. The documents will be kept confidential and not shared with third parties, such as insurance companies. All information on or attached to these forms is true and correct to the best of my knowledge.

APPLICANT'S SIGNATURE

WITNESS (if applicant signs with an "X")

(Parent/Guardian Signature if under 18)

Rev: 4/21/15