Florida Lions Foundation for the Blind, Inc.

ELIGIBILITY APPLICATION FOR FINANCIAL ASSISTANCE

APPLICANTS NAME: _____ MARITAL STATUS: _____

RESIDENTIAL ADDRESS: _____

MAILING ADDRESS: _____

OWN/RENT: _____ HOW LONG HAVE YOU LIVED HERE? _____

PREVIOUS ADDRESS: _____

HOME PHONE: ( ) _____ CELL PHONE: ( ) _____ EMAIL ADDRESS: _____

SSN: _____-____-_____ SPOUSE SSN: _____-____-_____ APPLICANTS DATE OF BIRTH: _____/_____/_____ AGE: _____

GENDER: M_____ F_____ DIABETIC: YES_____ NO_____

IF MINOR, PARENT/GUARDIAN NAME: _____

ADDRESS IF DIFFERENT THAN ABOVE: _____

NUMBER OF DEPENDENTS_____ GREEN CARD # (IF APPLICABLE) _____

EMPLOYER: _____ EMPLOYER PHONE: ( ) _____ FULL TIME/PART TIME: _____

MONTHLY HOUSEHOLD INCOME

(list all sources)

TOTAL HOUSEHOLD INCOME: $_____ WAGES/SALARY/TIPS: $_____ SOCIAL SECURITY: $_____

UNEMPLOYMENT/WORKERSCOMP: $_____ RETIREMENT/PENSION: $_____ SSI/SSD/DAV: $_____

INTEREST/DIVIDENDS: $_____ WELFARE/PUBLIC ASSIST/FOOD STAMPS: $_____ CHILD SUPPORT: $_____

SELF EMPLOYED: $_____ OTHER INCOME: $_____

MONTHLY HOUSEHOLD EXPENSES

(list all expenses)

RENT/MORTGAGE: $_____ PHONE: ( ) _____ MEDICAL INS: $_____ VEHICLE INS: $_____

WATER/SEWER: $_____ CABLE: $_____ PRESCRIPTIONS: $_____ GAS: $_____

ELECTRIC: $_____ LOANS: $_____ OTHER: $_____ LOAN: $_____

FINANCIAL COMMENTS:

_____

_____

_____

_____

MEDICAL INSURANCE INFORMATION

MEDICARE NUMBER: _____ **(A) OR (A & B) MEDICAID:** _____

OTHER INSURANCE PROVIDER: _____ **POLICY:** _____

POLICY HOLDERS NAME: _____

DIVISION OF BLIND SERVICES DATE DENIED: _____ **VOCATIONAL REHABILITATION DATE DENIED:** _____

TYPE OF ASSISTANCE NEEDED: _____

_____

_____

_____

I hereby certify that the above information is correct and do hereby give my full consent to investigate.

_____ _____

Applicant Signature **Date**

_____ _____

Lion-Processor Signature **Date**

Lions Club Notes:

_____

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THIS FORM IS FOR LIONS CLUB USE ONLY