



Lions Sight Foundation of Clark County

P.O. Box 1804
Vancouver, WA 98668-1804



We prefer you **email** applications to: lsfocc@gmail.com

Applicants must complete ALL sections of the application to be eligible.

Incomplete applications will result in delay or denial of service. Leaving items marked with an asterisk(*) blank will mean the application is incomplete. Mark N/A, if does not apply.

Applicants must have resided in Clark County **at least one year** and can only apply every **two years**.

Please Print

Last Name *		First Name *		Middle Initial	Date of Birth *	Age
Parent or Guardian Name(s)(if applicant is under 18 years of age)						
Street *		City *		State *	Zip *	
Driver License (or ID) Number * & State *			Home Phone		Cell Phone	
Email Addresses (please print):						
Applicant's email: *						
Referring Agency email:						
List ALL household members and Ages				Do you live in Clark County? (circle one) Yes / No *		
				How long have you lived in Clark County? * _____		
Are you a citizen of the USA? (circle one) Yes / No *						
If NO, Do you have a United States PERMANENT RESIDENT CARD? (circle one) _____ Yes / No						
Does applicant have Vision Insurance coverage? NO /YES * Insurance Provider: If YES Does insurance cover EXAM only, EXAM and GLASSES, NEITHER *						
Circle your appropriate Medical coverage: * Medical coupons Medicare Medicaid Employer or Private Insurance None Other:						
Circle services needing help with: * Eye Exam - Eye Glasses - Low Vision Aid - Other						
Date of your last eye exam: *			Clinic or Doctor who performed the exam: *			
Signature of Applicant *					Date *	

COMPLETE ALL SECTIONS ON THE REVERSE SIDE

Complete **ALL** Blanks

MONTHLY INCOME FOR ENTIRE HOUSEHOLD

*"Take Home" pay from Employment for the ENTIRE household	\$
*Social Security Benefits (total for all family members)	\$
*Child Support (actual amount you receive each month)	\$
*Retirement Benefits	\$
*Veteran's Benefits	\$
*Public Assistance (AFDC, GAU, SSI, Food Stamps)	\$
*Unemployment Benefits (weekly x 4 + ?)	\$
*Other Income (specify)	\$
*TOTAL MONTHLY INCOME	\$

If you have little or no income, or if you are homeless, fully explain how you are able to support yourself; for example, who you are living with and who is supporting you.

PERSONAL ASSETS

Vehicle #1	Year	Make	State	\$
Vehicle #2	Year	Make	State	\$
*Savings Account(s)				\$
*Checking Account(s)				\$

MONTHLY EXPENSES

*Housing (Circle One) Rent or Mortgage Payment	\$
*Food	\$
*Utilities: Electric	\$
*Water	\$
*Home Telephone	\$
*Cell phone	\$
*Vehicle Fuel	\$
*Car Payment(s) (specify vehicle and amount each)	\$
*Insurance Cost	\$
*Medical Bills	\$
*Dental Bills	\$
*Medical/Dental Insurance	\$
*Loan Repayment (specify)	\$
*Credit Card Payments	\$
*Other Monthly Expenses (specify)	\$
*MONTHLY EXPENSES	\$

THIS SECTION FOR USE OF LIONS SIGHT FOUNDATION COMMITTEE Form # LSFCC 07/2019

Approved Doctor /Clinic _____ VOUCHER # _____

Denied Reason _____

LSFCC AUTHORIZING SIGNATURE _____ DATE _____