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 * | 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? *___________

Does applicant have Vision Insurance coverage? YES / NO

* If YES, Circle appropriate Medical Coverage

Medicaid Medicare Employer or Private Insurance None Other: ________________________

Does insurance cover: EXAM only, EXAM and GLASSES, NEITHER

Name of insurance provider: _________________ Provider # / Member ID:_______________________

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.

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PERSONAL ASSETS

Vehicle #1	Year	Make	State	$
Vehicle #2	Year	Make	State	$
*S avings 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 10/04/23

Approved Doctor /Clinic _____________ VOUCHER # ____ Denied Reason LSFCC

AUTHORIZING SIGNATURE _______ DATE _______

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