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| **MOUNTAIN HOME LIONS CLUB** P.O. Box 58 Mountain Home Arkansas 72654-0058 870-425-2266 **SIGHT CARE ASSISTANCE APPLICATION**  ARE YOU A PATIENT OF THE CHRISTIAN CLINIC YES [] OR NO []  **\**IF YES, PLEASE SEE CLINIC STAFF FOR FURTHER ASSISTANCE***  ***DO NOT LEAVE ANY QUESTIONS BLANK. IF NOT APPLICABLE, INDICATE WITH N/A*** | | | | | | | | | | | | | | | | | | | |
| NAME: | | | | | | | | SSN: | | | | | | | | | | | |
| DOB: | | | | | | | | AGE: | | | | | | | | | | | |
| ADDRESS: | | | | | | | | | | | | | | | | STATE: | | | |
| CITY: | | | | | | | | | | | | | | | | ZIP: | | | |
| PHONE: | | | | | | | | | | **MONTHLY INCOME:** | | | | | | | | | |
| DO YOU HAVE HEALTH/VISION INSURANCE | | | | | | | | | | | | | EYE DR: | | | | | | |
| **PARENTAL/LEGAL GUARDIAN INFORMATION:** | | | | | | | | | | | | | | | *If Under 18:* | | | | |
| NAME: | | | | | | | | | RELATIONSHIP: | | | | | | | | | | |
| DOB: | | | | | | | | | SSN: | | | | | | | | | | |
| SPOUSE: | | | | | | | | | PHONE: | | | | | | | | | | |
| **FINANCIAL INFORMATION:** | | | | | | | | | | | | | | | | | DEPENDENTS#: | | |
| EMPLOYER: | | | | | | SPOUSE EMPLOYER: | | | | | | | | | | | | Age | |
| POSITION: | | | | | | | POSITION: | | | | | | | | | | | Age | |
| HOW LONG: | | | | | | | HOW LONG: | | | | | | | | | | | Age | |
| INCOME: | | | | | | | INCOME: | | | | | | | | | | | Age | |
| HOW OFTEN: | | | | | | | HOW OFTEN: | | | | | | | | | | | Age | |
| WORK PHONE: | | | | | | | WORK PHONE: | | | | | | | | | | | Age | |
| OWN A VEHICLE? | | | | YEAR/MAKE: | | | | | | | | | | YEAR/MAKE: | | | | | |
|  | | | | | | |  | | | | | | | |  | | | | |
| OWN/RENT HOME? | | | | | RENT/PAYMENT: | | | | | | | OTHER PROPERTY: | | | | | | | |
|  | **OTHER LOANS, DEBT, OR OBLIGATIONS:** | | | | | | | | | | | | | | Please list: | | | | |
| DESCRIPTION/ACCT #: | | | | BALANCE: | | | | | | | MONTHLY PAYMENT: | | | | | | | | |
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|  | **PLEASE DESCRIBE VISION PROBLEM & REQUEST:** |  | | | | | | | | | | | | | | | | | |
|  | Has applicant applied for sight care assistance at the Christian Clinic? If yes, please describe; if not eligible, please indicate the reason: | | | | | | | | | | | | | | | | | | ***Are you a patient of the Christian Clinic?*** |
|  | Name of person/organization who referred you to the Lion’s Club: | | | | | | | | | | | | | | | | | | Lions Member? |
|  | Has the person needing care received assistance from the Lion’s Club previously? If yes, Date? | | | | | | | | | | | | | | | | | |  |
|  | By signing below I agree that all of the information provided is true and correct and I authorize The Mountain Home Lions Club to verify any or all of the information provided. | | | | | | | | | | | | | | | | | | *\*Sign Below* |
|  | SIGNATTURE : | | | | | | | | | | | | | | DATE: | | | | |
| For Club Use Only: | | | ACTION TAKEN:  [ ] APPROVED [ ] DECLINED [ ] REFERRED [ ] OTHER | | | | | | | | | | | | DATE: | | | | |