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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:  |