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:	

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: