5150 East Pacific Coast Highway | Suite 605 | Long Beach, CA 90804 (800) 647-6638 | Fax (888) 958-7554 | admin@lshf.org

APPLICATION FORM

Please direct questions about the Sight and Hearing Programs directly to the LSHF Office at the address and/ or phone number set forth above. In general eligible persons have a significant need to restore or maintain sight or hearing with no medical coverage. They earn between 133% and 175% of the Federal Poverty Level, reside in Southern California, and have no property other than their home and/ or a car. Contact the Program Administrator in the LSHF Office with questions about how to complete the application form and to identify the appropriate documents to include to verify eligibility.

Personal Information: Today's Date: ______________

Name:____Sex: M F Date of Birth: ________________

Home Phone: ( )____________________________Email Address:_________________________________

Home Address:_________________________________City:______________________Zip Code: _________

Social Security #:__________________________How long have you lived in Southern CA? : ______________

IMPORTANT: To verify your identity, include with your application, copies of your SS card, driver license, passport, or visa. Also include copies to show you have been in Southern California for more than 3 years such as a birth certificate, utility bills, or some document with your name and address.

Which program are you applying to for assistance? Sight ______________ Hearing __________________

Have you seen a doctor about this concern? Yes___________ No___________

If "Yes" Name of Doctor:______________________________________Phone #: _______________________

Address:____Suite #: __________________

City:____State:__________Zip Code: ____________

What is the diagnosis? ____

For the Sight Program, what surgery is recommended? ____

IMPORTANT: Include copies of your Doctor's report showing the diagnosis and prognosis with your application.

List your Insurance, (Med-Cal, Medicare, Other (Specify) ____

LSHF File #:____________________

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Financial Information:

List all source(s) of Income:____

IMPORTANT: Enclose the first two (2) pages of last year's income tax return. If not required to file, attach copy of proof of income. (W-2, Check pay stubs, etc.)

Monthly Budget: This is the total monthly income and expense of the household. Number in the household: _____

1. Income Amounts: First__________Second_____________Child Support________________Other ___________

(Example of Other: Food Stamps, ADC, Interest, Dividends, etc) **Total Monthly Income $__________________**

2. Monthly Expenses (approximate amounts)

Rent and/ or Mortgage payment	$___________
Utilities (Phone, Gas, Water, etc)	$___________
Groceries	$___________
Insurance (Auto, Health, Life, Property, etc)	$___________
Installment Payments (Indicate date of final payment)	
Auto (date)____________________________	$___________
Loan (date)____________________________	$___________
Charge Cards (date)_________________	$___________
Other Monthly Expenses	$___________
Child Support	$___________
Medical	$___________
Total Monthly Expenses	**$___________**

IMPORTANT: Explain any unusual income or expense on a separate page and attach to your application.

Property Ownership: List any and all property owned by the house hold, valued over $4000.00, other than the home you live in and your car. ____

____

ONLY COMPLETE FOR APPLICANTS WHO ARE UNDER 18 YEARS OLD:

Any Applicant under 18 years old MUST have an authorization before being accepted. Responsible person please read and sign below.

I am aware of this request for assistance from the LSHF and am willing to accept the funding as provided by LSHF for this minor child.

Signature:____Social Security: ______________________

Relationship to Applicant: ____

LSHF File #:____________________

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Release of Claims:

I for myself, my heirs, personal representatives, executors, administrators and successors or assigns, and on behalf of the applicant, if the applicant is other than myself, and I am the responsible party for the applicant, waive, release, and forever discharge The Lions Sight & Hearing Foundation of Southern California (LSHF) and California Lions Clubs, their officers, directors, agents, representatives, members, successors and all cooperating entities, their agents, employees, an successors from any and all claims, losses, damages, or debts, which now exist or may hereafter arise, known or unknown, in connection with my and/or the Applicant's participation with any service rendered through the LSHF. To the best of my knowledge, I represent and warrant that all information contained in this application is correct.

Release of Information:

I authorize any service provider to whom I am referred by LSHF and to the Lions Club to release to LSHF any information required, including recommended course of treatment, service performed, and any recommended follow-up. False statements are grounds for refusal of benefits.

Applicant Signature:___________________________________Date: _____________________________

Print name: ____

Referral Disclaimer:

LSHF has not granted any authority, expressed or implied, to any person, organization or governmental agency, including, but not limited to, any person, referral organization, Lion Club, physician, clinic, or hospital from whom you may have obtained this referral for, to act on behalf of or to otherwise bind LSHF in any manner whatsoever. Neither this application form nor your receipt of this application form from any such source is a representation from LSHF of any authority actual or apparent, in such source and all such expressions of authority are hereby disclaimed.

FOR LSHF OFFICE USE ONLY:

Referral by:____Date:_________Phone #: ( ) _____________

Address:____________________City:________________________State:____________Zip Code: _____________

Lions Club District:____________Lions Club Name: ____

Address:____________________City:________________________State:____________Zip Code: _____________

2/2015

LSHF File #:_______________