

# EVERETT CENTRAL LIONS CLUB

## APPLICATION FOR ASSISTANCE

Applicants full name: \_\_\_\_\_ Date of birth: \_\_\_\_\_

Address: \_\_\_\_\_ City \_\_\_\_\_ Zip \_\_\_\_\_

Phone: \_\_\_\_\_ Email: \_\_\_\_\_

Application is for : Self \_\_\_ Other (specify) \_\_\_\_\_

If patient is a minor, list parent or guardian: \_\_\_\_\_

What are you applying for? Eye Exam \_\_\_ Glasses \_\_\_ Hearing Exam \_\_\_ Hearing Aid \_\_\_

Other (Specify) \_\_\_\_\_

### Sources of Income and Amount:

\_\_\_\_\_ \$ \_\_\_\_\_ ; \_\_\_\_\_ \$ \_\_\_\_\_

\_\_\_\_\_ \$ \_\_\_\_\_ ; \_\_\_\_\_ \$ \_\_\_\_\_

Savings Amount \_\_\_\_\_ \$ \_\_\_\_\_

### Expenses (Monthly) Approximate Amount:

Rent/ Mortgage \_\_\_\_\_ \$ \_\_\_\_\_

Utilities \_\_\_\_\_ \$ \_\_\_\_\_

Car payment/ Insurance \_\_\_\_\_ \$ \_\_\_\_\_

Food: \_\_\_\_\_ \$ \_\_\_\_\_ ; Other (Specify) \_\_\_\_\_ \$ \_\_\_\_\_

Health Insurance \_\_\_\_\_ \$ \_\_\_\_\_ Inc. Medicaid or Medicare \_\_\_\_\_

Does it cover this procedure? \_\_\_\_\_

Other pertinent information \_\_\_\_\_

Could you make monthly payments to pay back the Lions Club? \_\_\_\_\_ Amount \_\_\_\_\_

For hearing aid(s) there is a \$50 co-pay at time of visit.

Applicants or Parent's signature: \_\_\_\_\_ Date: \_\_\_\_\_

### Return completed form to:

### *For Club use only:*

Lee A. Woodard, VP Lions Sight & Hearing  
Everett Central Lions Club  
PO Box 2302  
Everett, Wa. 98213

Date application received: \_\_\_\_\_

Action Taken: \_\_\_\_\_

Ph: 425.493.4200

Email: lee@lwoodard.com