LIONS SIGHT & HEARING FOUNDATION OF SOUTHERN CALIFORNIA

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

APPLICANT INFORMATION FORM

Date: _____

The Lions Sight & Hearing Foundation of SC (LSHFSC) 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 or physician from whom you may have obtained this referral for, to act on behalf of or to otherwise bind the LSHFSC in any manner whatsoever. Neither this application form nor your receipt of this application form from any such source is a representation from the LSHFSC of any authority actual or apparent, in such source and all such expressions of authority are hereby disclaimed. You should direct any questions regarding the services available through the LSHFSC eligibility for such service, the cost of such services and this Referral Form directly to the LSHFSC offices at the address and or phone number set forth above. There is no application fee associated with the submittal to and review by the LSHFSC of this referral form.

Applicant: Miss, Mrs., Ms., Mr. (circle one)

Name: _____ Sex: M F Home Phone: ( ) _____

Home Address: _____ City: _____ Zip Code: _____

Date of Birth: _____ Age: _____ Social Security #: _____Citizenship: _____

Occupation: _____ Employer_____ Phone ( ) _____

Business Address: _____ City: _____ State: ____ Zip Code: _____

Contact Person: _____ Relationship: _____ Phone: ( ) _____

Total number of persons in household: Adults: _____ Children: _____ Ages of Children: _____

Best Day and Time to Call Applicant: _____

MONTHLY BUDGET: This is the monthly income and expense of the household.

1. Income: Husband_____ Wife_____ Child Support _____Other_____
Other Income (e.g. SSI, SS, Food Stamps, ADC, Interest, Dividends. Royalties, etc).

TOTAL MONTHLY INCOME **$_____**

2. Monthly Expenses (approximate amounts)

Rent and 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 EXPENSE **$_____**
Please include any unusual and extraordinary expenses on a separate sheet

IMPORTANT: Please 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.)

LSH File #:_____

Applicant Information Form cont'd

Amount you can pay towards this need: $ _____

Has a specific source guaranteed ANY payment towards this need? Yes _____ No _____

If "Yes" Name of Organization: _____ Amount $ _____

Contact Person: _____ Phone #: ( ) _____

Insurance, (Medical, Medicare, Other (Specify) _____

Have you seen a doctor concerning your particular need? Yes _____ No _____

If "Yes" Name of Doctor: _____ Phone #: _____
(Include copies of any information which you may have concerning your need) Diagnosis:

_____

_____

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 LSHFSC and am willing to accept the services as provided by them for this minor child.

Signature: _____ Social Security: _____

Relationship to Applicant: _____

Sight Applicants: Those affected by **diabetes MUST** have a note from the attending physician regarding the status of the disease **before** any surgical procedure is done.

Please describe visual/hearing problem: _____

_____

Physician, Eye Specialist, Audiologist or Dispenser:

Name: _____ Phone #: ( )_____ Email: _____

Address: _____ Suite #: _____

City: _____ State: _____ Zip Code: _____

LSH File #:_____

Applicant Information Form cont'd

RELEASE: I for myself, my heirs, personal representatives, executors, administrators and assigns, and on behalf of the patent if the Applicant is other than myself and I am the responsible party for the Applicant, waive, release and forever discharge the LSHFSC and California Lions Clubs, their officers, directors, agents, representatives, successors and all cooperating entities and individuals from any and all claims, losses, damages, or death, which now exist or may hereafter arise in connection with my and/or the Applicant's participation with or any service rendered through the LSHFSC. To the best of my knowledge, I represent and warrant the above information to be correct. **RELEASE OF INFORMATION:** I authorize any service provider to whom I am referred by LSHFSC and to the Lions Club to release to the LSHSC any information required, including recommended course of treatment, service performed, and any recommended follow-up. False statements are grounds for refusal of benefits.

Signature: _____ Date: _____

Print name:_____

FOR LIONS OFFICE USE ONLY:

Investigation /Referral by Lion: _____ Date: _____ Phone #: ( ) _____

Lions Club: _____Address:_____ City: _____ State: ___ Zip Code: _____

Approved: _____ Referred to: _____ Rejected: _____

FOR LSH OFFICE USE ONLY:

Date Received: _____ Date to Committee: _____

LSH File #:_____

LIONS SIGHT & HEARING FOUNDATION OF SOUTHERN CALIFORNIA

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

APPLICANT REFERRAL FORM

APPLICANT: Date: _____

Ms.
Mr._____Birthdate:_____ Age: _____
LAST FIRST MIDDLE

Home Address_____
STREET CITY STATE ZIP CODE

Home Phone#_____FAX#_____EMAIL_____

Occupation_____Employer_____ Social Security #_____

Business Address_____
STREET CITY STATE ZIP CODE

Business Phone #_____Spoken Language(s) _____Best Day & Time to Call_____

Does this Person need FINANCIAL ASSISTANCE? YES____ No_____

Medi-Care Number: _____ Medi-Cal Number_____

Other Medical Coverage_____Carrier_____Policy #_____

SPOUSE, PARENT or FRIEND who is able to assist with forms if need:

Name: _____ Relationship_____

Address: _____
STREET CITY STATE ZIP CODE

Phone #_____ FAX #_____ EMAIL_____

EYE SPECIALIST, AUDIOLOGIST or HEARING AID DISPENSER:

Name: _____ Phone #_____

PLEASE DESCRIBE VISUAL OR HEARING PROBLEM:

_____

_____

Referred by Lion Member_____ Phone #_____FAX #_____EMAIL_____

Club Name_____ District #_____Phone #_____

Club Address_____
STREET CITY STATE ZIP CODE

NOTE: Hearing Aids dispensed are on loan and are requested to be returned when no longer needed.

LSH is not free. All Applicants are requested to pay according to their ability.

Release of Information: I hereby authorize any service provided to whom I am referred by LSH to release to LSH and to the referring Member Lions Club any information, including Medical Information that may be appropriate for purposes of tracking the referral, and recommended course of treatment, the services performed and any recommended follow up.

_____ _____
Applicant's Signature Date

LSH File #:_____