



We Serve

Ashland Evening Lions Club Eye Care Application

Complete this form as accurately as possible.
All information will be kept confidential and used
only for the purpose of determining eligibility for
this program.

Send the completed form to:
Sight Committee Chair
P. O. Box 425
Ashland OH 44805

PERSONAL INFORMATION

Patient Name _____
Address _____
City _____
Total Number in Family _____
Parent/Guardian _____

Date of Application _____
Telephone _____
Patient Age _____
Referred by _____
Marital Status _____

INCOME

Employed by _____
Spouse Employed by _____
Other Income Source _____

Weekly Pay _____
Weekly Pay _____
Weekly Amount _____

EXPENSES

Monthly Rent or Mortgage _____
Other Regular Expense _____

Monthly Utilities _____
Other Regular Expense _____

Please explain any other circumstances which you would like us to consider in determining your eligibility
(use the other side if necessary):

EYE CARE REQUEST

What type of eye care do you need? _____

Preferred Eye Doctor _____ Doctor's Phone _____

How much can you pay towards your exam or glasses? _____

In signing here, you are confirming that the above information is accurate and complete.

Signature _____

*****For Committee Use Only*****

Date Received _____

[] Approved [] Not Approved [] Referred to:

Date of Final Decision _____

Reason for Not Approving _____

Additional Notes _____