PO Box 25495
Prescott Valley, AZ 86312
Info@PrescottValleyLions.org
(928) 848-6757

Application for Assistance

Instructions:

- Application must be completed in full (two pages). Incomplete applications will not be considered or processed
- Mail completed application to the above address
- Adults may apply every three years
- Minors under 18 may apply annually
- Residents of Prescott Valley only
- Please attach **PROOF OF INCOME** such as: W2, Paystub, 1st page of last year's tax return, benefit/disability letter from Social Security Administration
- **$10** Co-Pay required at time of visit

Assistance is limited to standard eye exam and glasses through Rummel Eye Care. Upgrades *without* prior approval beyond unbreakable or scratch resistant lenses will disqualify assistance of the exam and glasses. By signing the bottom of this form you authorize the PV Early Bird Lions to receive exam and lens info about your care from Rummel Eye Care and Rummel Optical.

Applicant's Name _____ Date of Birth _____

Requesting: ☐ Eye Exam ☐ Glasses ☐ Other _____

Have you received assistance from the Lions in the past? ☐ No ☐ Yes (Year) _____

Street Address _____

City, State, Zip _____

Phone _____

School Attending and Grade or Referred by _____

Household/Family Members (Name):

Father/Husband _____ Age _____

Mother/Wife _____ Age _____

Child _____ Age _____

Child _____ Age _____

Child _____ Age _____

Child _____ Age _____

Child _____ Age _____

Monthly Income for All Members in Household

Provide Net/Take Home Pay per Month:

Father's or Husband's Employer $ _____

Mother's or Wife's Employer $ _____

Total Income (Net/Take Home Pay) $ _____

Other Income: VA, SSI, SS, Food Stamps, ADC, and Spouse/Child Supp. $ _____

TOTAL MONTHLY INCOME $ _____

Monthly Expenses

Expense Type (Column A)	$ per Month	Expense Type (Column B)	$ per Month
Rent/Mortgage		Phone	
Gas		Water	
Trash/Sewer		Electricity	
Cable/Satellite TV		Laundromat	
Groceries/Food		Auto Insurance	
Life/Health Insurance		Auto Loan(s)	
Other Loan(s)		Credit Card Payment(s)	
Auto (gas/oil)		Dr. Bills	
Prescriptions		Other Expense	
Total A		Total B	

TOTAL MONTHLY EXPENSES (Columns A & B) $ _____

AMOUNT FAMILY CAN PAY TOWARD ASSISTANCE $ _____

Do you have insurance to cover exam? Yes ☐ No ☐

If yes, Name of Company_____

To the best of my knowledge the above information is correct.

_____ _____

SIGNATURE of APPLICANT or GUARDIAN **Date**

_____

Printed Name of Applicant or Guardian

CLUB ACTION

Approved: ☐ Yes ☐ No, Reason _____ Date _____

Financial Need: ☐ Yes ☐ No

Decision Letter Sent _____

Service Authorization Sent _____ ☐ Not Applicable (Denied)