



## Application for Vision Assistance

**Instructions:**

- Application must be completed in full and **include** income documentation or it will **not** be considered or approved
- Mail completed application to the above address
- Adults may apply every three years; Minors under 18 may apply annually
- Residents of Prescott Valley only
- **\$10** Co-pay required at time of visit

Name of Applicant: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Street Address: \_\_\_\_\_

City, State, Zip: \_\_\_\_\_

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

Services Requested by (Name): \_\_\_\_\_

Relationship to Applicant:  Self  Parent/Guardian  Other (describe) \_\_\_\_\_

Requesting:  Eye Exam  Glasses  Other \_\_\_\_\_

Have you received assistance from the Lions in the past?  No  Yes (Year) \_\_\_\_\_

School, Agency Referring: \_\_\_\_\_

### Household Income

Provide amount of monthly income and source (Ex. Employment, Social Security, Food Stamps, Spouse/Child support, Veterans Assistance, etc.) for **all** Household/Family Members. **Proof** of income **must be attached** for all **sources of income** or the application **will be returned/denied**.

Household Income*	Amount & Source (1)	Amount & Source (2)	Amount & Source (3)	Total (1-3)
<b>Applicant</b>	\$ _____ _____	\$ _____ _____	\$ _____ _____	\$ _____
<b>Household Member(s) w income</b> Name, age, and relationship to applicant				
	\$ _____ _____	\$ _____ _____	\$ _____ _____	\$ _____
	\$ _____ _____	\$ _____ _____	\$ _____ _____	\$ _____

**TOTAL MONTHLY INCOME (ALL) \$ \_\_\_\_\_**

**\*Provide proof of all income**

List all minor children (Name/Age) \_\_\_\_\_

You may include a comment or explanation to support your request: \_\_\_\_\_

**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 \_\_\_\_\_

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 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.

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

\_\_\_\_\_  
**SIGNATURE of APPLICANT or GUARDIAN**

\_\_\_\_\_  
**Date**

\_\_\_\_\_  
Printed Name (legible please) of Applicant or Guardian

CLUB ACTION

Approved:  Yes  No, Reason \_\_\_\_\_ Date \_\_\_\_\_

Financial Need:  Yes  No

Decision Letter Sent \_\_\_\_\_

Service Authorization Sent \_\_\_\_\_  Not Applicable (Denied)