PO Box 25495
Prescott Valley, AZ 86312
pveblions22@gmail.com
(775) 721-6817

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, Dewey, Humboldt 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)**
Applicant	$_____ _____	$_____ _____	$_____ _____	$_____
Household Member(s) w income 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)