LIONS
SIGHT & HEARING FOUNDATION
OF SOUTHERN CALIFORNIA

3450 East Spring Street | Suite 212 | Long Beach, CA 90806 **(800) 647-6638 | Fax (888) 958-7554 | admin@lshf.org**

APPLICATION FORM

Please direct questions about the Sight and Hearing Programs directly to the LSHF Office at the address and/ or phone number set forth above. In general eligible persons have a significant need to restore or maintain sight or hearing with no medical coverage. They earn from $15,000 up to $30,000 in adjusted gross annual income for one person, reside in Southern California, and have no property other than their home and/ or a car. Contact the Program Administrator with questions about how to complete the application form and to identify the appropriate documents to include to verify eligibility.

Personal Information: Today's Date: _____

Name: _____ Sex: M F Date of Birth: _____

Home Phone: ( ) _____ Email Address: _____

Home Address: _____ City: _____ Zip Code: _____

Social Security #: _____ How long have you lived in Southern CA? : _____

IMPORTANT: To verify your identity, include with your application, copies of your SS card, driver license, passport, or visa. Also include documents to show you have been in Southern or the Central Coast of California for more than 3 years such as a birth certificate or bills with your name and address.

Which program are you applying to for assistance? Sight _____ Hearing _____

Have you seen a doctor about this concern? Yes_____ No_____

If "Yes" Name of Doctor: _____ Phone #: _____

Address: _____ Suite #: _____

City: _____ State: _____ Zip Code: _____

What is the diagnosis? _____

For the Sight Program, what surgery is recommended? _____
IMPORTANT: Include copies of your Doctor's report showing the diagnosis and prognosis with your application.

List your Insurance, (Med-Cal, Medicare, Other (Specify) _____

LSHF File #: _____

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Financial Information:

List all source(s) of Income:_____

IMPORTANT: Enclose proof of income such as the first two (2) pages of last year's income tax return. If not required to file, attach W-2, Check pay stubs, or bank statements showing income deposits.)

Monthly Budget: This is the total monthly income and expense of the household. **Number in the household:** _____

1. Income Amounts: First_____Second_____Child Support_____Other _____

(Example of Other: Food Stamps, ADC, Interest, Dividends, etc) **Total Monthly Income $**_____

2. Monthly Expenses (approximate amounts)

Rent and/ or 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	$_____
Total Monthly Expenses	**$**_____

IMPORTANT: Explain any unusual income or expense on a separate page and attach to your application.

Property Ownership: List any and all property owned by the house hold, valued over $4000.00, other than the home you live in and your car. _____

_____

ONLY COMPLETE 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 LSHF and am willing to accept the funding as provided by LSHF for this minor child.

Signature:_____Social Security: _____

Relationship to Applicant: _____

LSHF File #:_____

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Release of Claims:

I for myself, my heirs, personal representatives, executors, administrators and successors or assigns, and on behalf of the applicant, if the applicant is other than myself, and I am the responsible party for the applicant, waive, release, and forever discharge The Lions Sight & Hearing Foundation of Southern California (LSHF) and California Lions Clubs, their officers, directors, agents, representatives, members, successors and all cooperating entities, their agents, employees, an successors from any and all claims, losses, damages, or debts, which now exist or may hereafter arise, known or unknown, in connection with my and/or the Applicant's participation with any service rendered through the LSHF. To the best of my knowledge, I represent and warrant that all information contained in this application is correct.

Release of Information:

I authorize any service provider to whom I am referred by LSHF and to the Lions Club to release to LSHF any information required, including recommended course of treatment, service performed, and any recommended follow-up. False statements are grounds for refusal of benefits.

Applicant Signature:_____ Date: _____

Print name: _____

Referral Disclaimer:

LSHF 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, physician, clinic, or hospital from whom you may have obtained this referral for, to act on behalf of or to otherwise bind LSHF in any manner whatsoever. Neither this application form nor your receipt of this application form from any such source is a representation from LSHF of any authority actual or apparent, in such source and all such expressions of authority are hereby disclaimed.

Referral Information:

Referral by:_____ Date:_____ Phone #: ( ) _____

Address:_____ City:_____ State:_____ Zip Code: _____

Lions Club District:_____ Lions Club Name: _____

Address:_____ City:_____ State:_____ Zip Code: _____

10/2018

LSHF File #:_____