

SANTA CRUZ HOST LIONS CLUB



Assistance Application for Eye Exam/Glasses
(To Be Completed by Applicant)

INSTRUCTIONS: After completing this form, mail to **Santa Cruz Host Lions Club**
P. O. Box 477; Santa Cruz, CA 95061 or fax to (831) 423-2352

Applicant's Name: _____ **DOB** _____

Address _____ **City** _____ **State** ____ **Zip** _____

If A Minor, Parents or Guardian Name: _____

Address(If Different) _____ **City** _____ **State** ____ **Zip** _____

Phone _____ **How Long Have You Resided in Santa Cruz County** _____

(must be included)

Alternate Contact Name _____ **Phone Number** _____

Are you a legal resident of the United States of America? _____

Net Monthly Salary \$ _____ **Number of Dependents on net income** _____

Do You Currently Have Vision Insurance? _____

Has Application Been Made to Medi Cal? _____ **Medi Cruz?** _____ **Other?** _____

IF APPROVED YOU WILL BE REQUIRED TO MAKE A CO-PAYMENT OF \$25.00
(DUE AT THE TIME OF SERVICE)

Please briefly explain how you specifically will benefit from the Lions Eye Fund Support:

APPLICANT'S SIGNATURE _____ **DATE** _____

LIONS CLUB AUTHORIZATION

APPROVED BY _____ **DATE** _____

APPROVED BY _____ **DATE** _____