



Elko Lions Club  
P.O. Box 13  
Elko, NV 89803

**SIGHT REFERRAL FINANCIAL FORM**

(Applications must be complete or they will be returned-rev. 11/07)

Patient's Name: \_\_\_\_\_ Age \_\_\_\_\_ Sex \_\_\_\_\_  
Telephone: \_\_\_\_\_ Address: \_\_\_\_\_  
City/State: \_\_\_\_\_ Zip Code: \_\_\_\_\_  
SS#: \_\_\_\_\_ Are you a US Citizen? Yes \_\_\_\_\_ No \_\_\_\_\_

Please describe the reason for requesting assistance for Lion Sight Care: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Marital Status: (please circle one) Married Single Divorced Widowed  
Employment Status: \_\_\_\_\_  
Parent/Guardian/Patient Employer: \_\_\_\_\_  
Employer's Complete Address: \_\_\_\_\_  
Position Held \_\_\_\_\_  
Years with present employer: \_\_\_\_\_ Telephone: \_\_\_\_\_  
Do they provide medical/eye insurance?: \_\_\_\_\_

Spouse's Name: \_\_\_\_\_ Employer: \_\_\_\_\_  
Employer's Address: \_\_\_\_\_  
Years with present employer: \_\_\_\_\_ Telephone: \_\_\_\_\_  
Do they provide medical/eye insurance?: \_\_\_\_\_

.....

Complete this section for ALL members of your household including parent and/or spouse noted above.

- 1. List everyone living in your household, include parents, all children, grandparents and any other person related or unrelated who share living expenses.
- 2. List the amount of gross income earned last month.

Names of ALL household members	Age	Gross Monthly Earnings	Month Welfare, Pensions, Unemployment, child support, Alimony and Social Security	Any other Income

Current medical coverage and policy number:

\_\_\_\_\_

Does the above insurance cover vision? \_\_\_ Yes \_\_\_ No  
(If your insurance covers eye care, please use your insurance.)

**HOME:** Own: \_\_\_\_\_ Rent \_\_\_\_\_ Length of Time: \_\_\_\_\_ Monthly Payment: \_\_\_\_\_

If renting, Landlord's Name: \_\_\_\_\_

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

If own: Purchase Price: \_\_\_\_\_ Balance Owed: \_\_\_\_\_

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

**AUTO:** \_\_\_\_\_ Year: \_\_\_\_\_ Model \_\_\_\_\_

Monthly Payment: \_\_\_\_\_ Balance Owed: \_\_\_\_\_

List any other major purchase(s) with monthly payment and balance:

1. \_\_\_\_\_

2. \_\_\_\_\_

3. \_\_\_\_\_

List any other expenditure(s), which affect your ability to provide eye care:  
(List monthly payment and balance)

1. \_\_\_\_\_

2. \_\_\_\_\_

3. \_\_\_\_\_

Please describe any special considerations that should be taken into account by the Eye Care Committee:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

I certify to the accuracy of the above statements. You are authorized to obtain information as you may require concerning the above statements made in this application.

APPLICANT'S SIGNATURE: \_\_\_\_\_

PARENT/GUARDIAN (if applicant is a minor): \_\_\_\_\_

*Any glasses purchased will be of basic design, without tinted lenses and expensive frames.*

Return your completed application form to: The Elko Lions Club, P.O. Box 13, Elko, NV 89803  
ATTN: Gwen E. King



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**EYE COMMITTEE CRITERIA**

**NEED:** Applicant must complete financial statement and application in full. *If application is incomplete it will be returned and this will delay assistance.* Welfare standards of poverty income level shall be used as criteria.

**EMPLOYMENT:** *Employment must be listed, if not employed must state reason.*

**AGE:** Age shall be considered as part of criteria. Preference shall be given to the young school age children, the elderly, retired individual and the handicap.

**RESIDENCE:** Applicant must be a permanent resident of Elko County and a citizen of the United States.

**APPLICATION:** Lions Club Eye Committee Application must be completed in full including Social Security number and denials by other agencies. *Should have applied for assistance from other agencies, prior to consideration by the Elko Lion's Club.*

**PROOF OF DENIAL:** Proof of denial *or signature* from other agencies should accompany application.

**EYE CARE:** A voucher for \$200 towards a pair of glasses will be sent to the applicant. The Lion's Eye Committee does not cover contact lenses, unless the doctor requires patient to have contact lenses. *If you have eye care insurance, please use that first and save the vouchers for those with none.*

**EMERGENCY REPLACEMENT:** Application for emergency replacement will be considered on individual basis.

*Please allow 30 days for the processing of your application.*

A cover letter requesting a report and update following treatment is enclosed with each voucher. A denial letter stating application does not meet the criteria shall be sent to all who are denied. An applicant shall receive one pair of glasses every two years.

Respectfully,

Gwen E. King  
Committee Chairperson