LIONS ASSOCIATION FOR SIGHT & HEARING OF MARYLAND, INC.
EYEGLASS ASSISTANCE REQUEST

Individuals with insurance that covers eyeglasses are not eligible for this program

Date of Request: ________________

Name of Person Applying for Eye Exam and/or Eyeglasses:

____ Age: ___________

Street Address: ______________________________________ Phone #: ______________________

City: ________________________ State: _____ ZIP: _________ Email:

Please describe on the lines below the background, justification and the financial need:
Describe the applicant's inability to pay for an exam and glasses. Does the applicant have a job? Have insurance? Does the insurance cover eye exams? Receive medical assistance?

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ATTACH THE INCOME QUALIFICATION FORM
Can the applicant pay $25.00 for an eye exam if needed? Y N (circle one)
If "YES" attach a $25.00 check/money order made out to L.A.S.H.

Date you last received eyeglasses: ___________________

Do you have a recent eyeglass prescription? ___________Date of the prescription: ________________

Is any assistance being provided by other organizations? Y N (Circle one)

Who: (give point of contact name with phone number): ______________________________________

Transportation: (How will you get to the eye exam and the eyeglass store?) ______________________

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How did you learn about Lions vision assistance? ____

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REFERRING PERSON & ORGANIZATION

Name: ____

Organization: ____

Position: (Nurse, counselor, case worker, etc.) ____

Address, FAX #, Phone # and Email address of referring person: ___________________________

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Return the completed form with a $10.00 Application Fee payable to L.A.S.H. to:

Lions Association for Sight & Hearing
Attn: Lion June Livingston
PO BOX 821
Bel Air MD 21014-0821