



UMPQUA LIONS CLUB
PO BOX 57
ROSEBURG, OR 97470

ROSEBURG LIONS CLUB
PO BOX 686
ROSEBURG, OR 97470

BREAKFAST LIONS CLUB
PO BOX 1553
ROSEBURG, OR 97470

APPLICATION FOR ASSISTANCE

REFERRAL CLUB _____ DISTRICT _____ DATE _____

Club President or Referring Lion _____ Phone _____

Address _____
Street _____ City _____ State _____ Zip _____

(PATIENT INFORMATION)

Patients Name _____ Phone _____ Birthdate _____ Age _____

Address _____
Street _____ City _____ State _____ Zip _____

Soc Sec # ____-____-____ Marital Status: Married____ Single____ Separated____ Widowed____ Divorced____

Patient's Occupation _____ Employer _____

Employer's Address _____
Street _____ City _____ State _____ Zip _____

Spouse's Name _____ Occupation _____ Employer _____

Next-of-Kin _____ Relationship _____ Phone _____

Address _____
Street _____ City _____ State _____ Zip _____

Head of Household _____ # of Dependants _____ Ages _____

Do You Receive: Social Security____ Unemployment Compensation____ Welfare____

Gross Monthly Income or Allotment \$ _____ Bank _____ Checking \$ _____ Savings \$ _____

Housing: OWN? _____ Equity \$ _____ Owe \$ _____ RENT? _____ Amount Per Month \$ _____

Other Assets (cars, stocks, bonds, business, certificates, etc.) _____

Total Indebtedness (not including spouse's) \$ _____ Monthly Payments \$ _____

**ALL QUESTIONS MUST BE ANSWERED ON BOTH SIDES OF APPLICATION.
IF NOT APPLICABLE, WRITE "NONE" IN BLANK.**

INSURANCE INFORMATION

Insurance Company _____ Group # or Name _____

Medicare # _____ Welfare # _____ Caseworker _____

Hospital Coverage Only _____ Hospital & Doctor Coverage _____

Policy Holder _____ Relationship _____

Address _____
Street City State Zip

Nature of Problem _____

Is your doctor aware of your applying to the Lions for assistance? _____

I hereby grant permission to release medical information on the condition of _____
to the Devers Memorial Eye Clinic, or other medical clinic, Audiologist, the above referral Lions Club, and/or
the Oregon Lions Sight and Hearing Foundation, Inc.

Signature of patient or patient's guardian

Signature of witness Date

Doctor's Name _____ Phone _____ Address _____

ARE YOU ABLE TO MAKE ANY CONTRIBUTION TO THE LIONS FOR YOUR CARE? _____

THE INFORMATION GIVEN ABOVE IS TRUE _____
Signature of patient, or patient's guardian

Relationship to patient _____ Date _____

(FOR OFFICIAL USE ONLY)

Action by Patient Care Committee: Accepted _____ Refused _____ Why _____ Date _____

Approval Signature _____

Hospitalization (over/above insurance); Total Funding \$ _____ Partial Funding \$ _____

Club Notified _____