

ROSEBURG UMPQUA LIONS CLUB

P O BOX 57
ROSEBURG, OR 97470



APPLICATION FOR ASSISTANCE

Referring Lion if applicable _____

PATIENT'S 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 Dependents** _____ **Ages** _____

Do you receive: Social Security _____ Unemployment Compensation _____ Welfare _____

Gross monthly income or allotment \$ _____ **Bank** _____ **Checking** _____ **Savings** _____

HOME - do you own your home _____ **Equity \$** _____ **Owe \$** _____ ; **Rent** _____ **Amount Per Month \$** _____

Other Assess (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 IN BLANK "NONE"

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 _____