



STANTON LIONS CLUB SIGHT AND HEARING COMMITTEE

Date _____

APPLICANT'S NAME _____ Age _____

ADDRESS _____

STREET

CITY

STATE

ZIP

OCCUPATION/Job _____

TOTAL FAMILY INCOME \$ _____ NUMBER OF DEPENDENTS _____

VALUE OF FAMILY PROPERTY _____

IS APPLICANT COVERED FOR VISION CARE BY MEDI-Cal or Medi-care? ____ .
MEDICAL INSURANCE? ____ CARRIER _____ POLICY # _____

REASON(S) FOR REQUESTING ASSISTANCE : _____

Does the applicant live in the city of Stanton? ____ Does the applicant have proof of
residency (motel bill, utility bill, Rent receipt...)? ____

**I HEREBY CERTIFY THAT THE FOREGOING INFORMATION IS A CORRECT
STATEMENT OF FACT.**

Applicant

REFERRED BY (Form Filled Out by):

NAME _____ TITLE _____

ADDRESS _____

BASIS OF REFERRAL _____

HAS THERE BEEN A PREVIOUS EYE EXAMINATION? ____ WHEN _____

PAID FOR BY LIONS CLUB? ____ CONTACT NUMBER (____) _____

Does the Applicant Speak English? ____ If Not, whom can we call regarding translation for
applicant? _____ Language applicant speaks? _____

MAIL TO:
STANTON LIONS CLUB
SIGHT AND HEARING COMMITTEE
10581 CHESTNUT ST.
STANTON, CA 90680

If you do not live in the Stanton area, please contact Cara to find Lions Club near you. (800)546-6634

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