



ROSEBURG LIONS CLUB  
P O Box 686  
Roseburg, OR 97470-0137

Phone: 541-229-6358

**Please provide proof of income with your application.** This can be a copy of your W-2 or past two payroll stubs for wages earned and a **copy of any benefits or approval letter** for social security, disability, unemployment, food stamps, HUD housing etc. **Applications received without the supportive documentation will not be processed.**

Upon approval of your application you will be required to pay a \$20.00 co-pay to the office providing the services. It must be submitted to the provider at the time of services.

Our club will pay for the exam, the frames, and clear-39 lenses. This will not cover extra expenses such as transition or progressive lenses. Should you want glasses costing more than what we can pay, the voucher will become null and void and you will be responsible for the entire bill.

If you have any questions about the application process, our sight and hearing chairperson can be reached at the above number.

**Please return completed application along with proof of income to the above address.**

Thank you for your cooperation and patience.

Sincerely,

Diana Stewart  
Roseburg Lions Sight and Hearing chairperson



# Lions Eyeglass Assistance Program

FOR USE BY LIONS CLUBS ONLY



**Applicant: Complete Sections 1, 2, and 3 and submit this application along with any requested documentation to the Lions Club listed in Section 4.**

**You will be notified of your application status by the Lions Club Volunteer.**

Applications are generally processed within several weeks but are dependent on staff and volunteer availability.

Your patience with this volunteer driven effort is appreciated.

Upon qualification, you are eligible for clear plastic or polycarbonate single vision, lined bifocal or lined trifocal lenses.

## Section 1: Applicant Information (please print)

**Request for:**  Eye Exam and Glasses  Glasses only (I have a current prescription)

Applicant First Name (legal)		Applicant Last Name		Applicant First Name (preferred)		Applicant Date of Birth	
HOME Address (if houseless, where do you usually reside)			Apt. #	Phone #		Alternative Phone #	
City		State	Zip Code	County	Email Address		
MAILING Address (If Different from Home Address)				City		State	Zip Code
Number of People in Household?		How Long Have you Lived in OR/Northern CA?		Occupation:		Preferred Written or Spoken Language(s)	
Who Can We Call With Questions?							
<input type="checkbox"/> Yourself		<input type="checkbox"/> Other		Name:		Phone Number: Relationship to You:	
<b>PLEASE NOTE: YOUR APPLICATION WILL NOT BE REVIEWED UNLESS PROOF OF INCOME IS INCLUDED.</b> <b>Proof of income may be: pay stubs from the last 2 recent pay periods, current DHS/TANF/SSI/Disability award letters, food stamp benefit letter, or awards letters from other government or state assistance programs.</b>							
MONTHLY GROSS INCOME (Before Taxes and Deductions)				INSURANCE INFORMATION			
Applicant Wages		\$		Do you have Vision Insurance?		Yes No	
Spouse/Domestic Partner's Wages		\$		If Yes, explain why you are requesting help from the Lions?			
Welfare Benefits		\$					
Social Security/Disability		\$		When was your last eye exam?			
Food Stamps		\$					
Other		\$		Name of the Provider/Clinic?			
<b>TOTAL MONTHLY INCOME</b>		<b>\$</b>					





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## Section 2: Authorization for Release of Information

I agree that my Lions Club in Section 4, the Oregon Lions Sight & Hearing Foundation, and their qualified partners and providers, may review and share between themselves the personal and income information I included with this application along with any additional information about my vision, such as an eyeglass prescription.

Yes \_\_\_ No \_\_\_

I agree to participate in and allow the Oregon Lions Sight & Hearing Foundation permission to use general interest information/quotes/photographs of myself for publicity, promotion, news releases, videos, and web use of the Oregon Lions Sight & Hearing Foundation. I hereby release and discharge the Oregon Lions Sight & Hearing Foundation from any and all claims arising out of the use of the above stated purposes that I may have in this regard.

Yes \_\_\_ No \_\_\_

I understand that I may revoke these authorizations in writing at any time by faxing a signed and dated letter to (503) 413-7522, except to the extent that the organization(s) named above may have acted in reliance on this authorization. I have had the opportunity to read and consider the contents of this authorization.

**Applicant or Guardian Signature**

**Date**

## Section 3: Fitting Fee Agreement

Depending on the provider your Lions Club is working with, there *may* be a \$20 copay when you receive your eyeglasses fitting. Please be prepared to pay that copay or provide an explanation on a separate sheet of paper as to why that cost would be a hardship for you at this time. Your local Lions Club will let you know about the copay when they process your request for assistance.

**Print First Name**

**Print Last Name**

**Phone Number**

**Applicant or Guardian Signature**

**Date**



**We Need Your Help! Please share your story with us.**

E-mail us at [Info@OLSHF.org](mailto:Info@OLSHF.org) or attach a separate piece of paper.



**Section 4 is for volunteer Sight & Hearing Chair use ONLY. Mail completed application and proof of income to the address located in the section below. If Section 4 is blank, please find your local Club by filling out the GET HELP FORM at [OLSHF.org](http://OLSHF.org) and you will be connected with your local Lions Club.**

## Section 4: Lions Club Contact Information

**Lions Club**

**Sight & Hearing Chair**

**Telephone**

**Mailing Address**

**City**

**State**

**Zip Code**

**E-mail Address**

**Please check here if using OLSHF's Optical Program and the LEAP Lab \_\_\_\_\_**

