Shelby County Lions Club
Eye Care Assistance Program
Application

Applicant's Name: _____ Date of Birth: _____

Address: _____ City: _____ Zip: _____

*Phone: (_____)_____-_____ *Email: _____

Have you had an eye exam in the past? ____ Yes _____ No Dr.'s Name: _____

Date of last exam: _____ Do you currently have eye glasses? ____ Yes _____ No

Are you needing: ___ First time glasses ____ Replacement glasses ____ Upgraded Glasses ____ Other

Are you covered by any type of insurance? ____ Yes _____ No

Type of Coverage: ____ Private Insurance _____ Medicare ____ Medicaid ____ Passport

Name of Card Holder : _____ Insurance card has to be shown at time of appointment

*Household size: _____. Household Income (Please include the income of all household members):

Name of Household Member	Gross Monthly Income	Source of Income
Gross Total Monthly Income		

This application must be completed, scanned or photographed and submitted to ShelbyLions@att.net for review and approval BEFORE you make an appointment with VisionFirst.

* Required information

The Shelby County Lions Club Eye Care Assistance Program does not and shall not discriminate on the basis of race, color, religion (creed), gender, gender identity, age, national origin, immigration status, disability, marital status, sexual orientation, or military status, in any of its activities or operations.

If your application is approved:

1. You will be notified of approval by phone or email.
2. Your contact information will be provided to VisionFirst in Shelbyville and they will contact you directly to schedule an appointment.
3. A voucher will be sent directly to Shelbyville VisionFirst notifying them of your level of financial assistance from the the Shelby Lions Club.
4. You will be responsible for giving any insurance coverage to VisionFirst at the time of the appointment.
5. Certain frames will be made available and should you need glasses you must select from these frames.
6. Only basic lenses will be covered by the Shelby Lions Club and should you need or choose other lenses (bifocal, trifocal, or progressive) you will be responsible for the additional cost of up to $32 which will be due at the time of ordering the glasses.

_____ (initials) I certify that the information given on this form is true and accurate at the time of completion and I agree to abide by the guidelines of the program.

I authorize the assisting community agency to share this application with the Shelby County Lions Club (SCLC) for the sole purpose of receiving vision care assistance. I also authorize SCLC to release my contact information to VisionFirst for services. I understand that it is entirely my decision to authorize the release of this information and that I may revoke this authorization at any time by contacting the assisting community agency or SCLC.

Applicant/Parent/Guardian Signature: _____ Date: _____

Referring Community Agency: _____

Contact Person:_____ Phone: _____

Date Application Received: _____
Reviewed by: _____
Approved _____ Denied _____
Reason for Denial: _____
Date Applicant Notified of Decision: _____

Completed Application must be scanned or photographed and emailed to ShelbyLions@att.net

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