GONZALES LIONS CLUB

APPLICATION FOR EYEGLASSES

DATE: _____ **INVOICE#:** _____
NAME: _____ **DOB:** _____ **SEX:** _____
ADDRESS: _____
CITY: _____ **STATE:** _____ **ZIP:** _____
DAYTIME PHONE#: _____ **CELL#:** _____

HEAD OF HOUSEHOLD NAME: _____

IS HEAD OF HOUSEHOLD EMPLOYED? YES NO **EMPLOYER:** _____
(CIRCLE ONE)

TOTAL INCOME OF HOUSEHOLD IS $_____ **PER WEEK**

PLEASE LIST AMOUNT NEXT TO EACH BENEFIT:

DISABILITY $_____ **WELFARE** $_____ **FOOD STAMPS** $_____

SOCIAL SECURITY $_____ **CHILD SUPPORT** $_____

DO YOU HAVE MEDICARE OR MEDICAID? YES NO
(CIRCLE ONE)

DOES HEAD OF HOUSEHOLD OWN A HOME? YES NO **DO THEY RENT?** YES NO
(CIRCLE ONE) (CIRCLE ONE)

HAVE YOU EVER APPLIED FOR AID FROM THE LIONS CLUB? YES NO **When?** _____
(CIRCLE ONE)

IF APPLICANT IS UNDER THE AGE OF 21, PLEASE GIVE THE FOLLOWING:

NAME OF PERSON WHO CAN VERIFY THE ABOVE INFORMATION (e.g., social worker, welfare agent, etc.):

NAME: _____ **LOCATION:** _____
PHONE#: _____ _____

NAME OF CURRENT EYE DOCTOR or CIRCLE IS YOU ARE CURRENTLY A PATIENT OF ONE OF THE FOLLOWING DRS. _____

- **DR. EVA LAMENDOLA AT ACCENT OPTICAL**
- **DR. ADAMS AT WILLIAMSON EYE CENTER**
- **DR. DEVJANI LAHIRI IN DONALDSONVILLE**

NAME OF CURRENT MEDICAL INSURANCE: _____

NAME OF CURRENT VISION INSURANCE: _____

_____ _____
SIGNATURE OF APPLICANT/GUARDIAN APPROVED BY

NOTE: ANY FALSE STATEMENTS MAY IN EFFECT VOID THIS APPLICATION. **RETURN TO: GONZALES LIONS CLUB**
C/O ANDREW BERTRAND
2001 S. BURNSIDE AVENUE
GONZALES, LA 70737

Last updated: March 28, 2022