



# Lions Charity Foundation

## of District 24D



**SERVING THE COMMUNITIES OF SOUTHEASTERN VIRGINIA**

Lion Edward "Moon" M. Kosjer Endowment Fund  
*Application for*

## FINANCIAL ASSISTANCE WITH EYECARE (LCF IV)

DATE

### LIONS CLUB INFORMATION

SPONSORING LIONS CLUB

RESPONSIBLE LIONS CONTACT

### RECIPIENT'S INFORMATION

NAME		SSN	SEX <input type="checkbox"/> FEMALE <input type="checkbox"/> MALE	AGE
ADDRESS				
CITY		STATE	ZIP	
HOME PHONE NO. ( )	WORK PHONE NO. ( )	NUMBER OF DEPENDENTS	AGES	

### WORK INFORMATION

EMPLOYER		OCCUPATION		
ADDRESS				
CITY		STATE	ZIP	
PHONE NO. ( )	SALARY / MONTH	HOW LONG HAVE YOU BEEN EMPLOYED?		

### FINANCIAL INFORMATION

DO YOU RECEIVE ANY OTHER INCOME? (EXAMPLE: SOCIAL SECURITY, DISABILITY OR AID TO DEPENDENT CHILDREN)		<input type="checkbox"/> YES <input type="checkbox"/> NO	SOURCE	AMOUNT PER MONTH
DO YOU RECEIVE ANY ASSISTANCE FROM ANY CHARITY? (EXAMPLE: MONIES, ETC.)		<input type="checkbox"/> YES <input type="checkbox"/> NO	SOURCE	AMOUNT PER MONTH
<b>MONTHLY EXPENSES</b>	1. RENT OR HOUSE PAYMENT	\$	6. INSURANCE	\$
	2. TRANSPORTATION	\$	7. FOOD	\$
	3. UTILITIES	\$	8. MEDICAL	\$
	4. CABLE	\$	9. MISCELLANEOUS	\$
	5. TELEPHONE	\$	<b>TOTAL MONTHLY EXPENSES</b>	\$

## FINANCIAL INFORMATION CONTINUED

DO YOU HAVE ANY FAMILY WHO WOULD ASSIST WITH THE PAYMENT OF YOUR MEDICAL OR DOCTOR BILLS?

YES  NO

NAME

AMOUNT

## INSURANCE INFORMATION

DO YOU HAVE MEDICAL INSURANCE OR ARE YOU COVERED BY MEDICARE, MEDICAID OR OTHER INSURANCE?

YES  NO

PLAN NAME

POLICY / CLAIM / CASE NO.

GROUP NO.

EFFECTIVE DATE

END DATE

MEDICARE

MEDICAID

## ASSISTANCE NEEDED

DESCRIPTION OF ASSISTANCE NEEDED

ESTIMATED COST

\$

## ACTION TAKEN

DESCRIPTION OF ACTION TAKEN

DATE

AMOUNT RECOMMENDED

\$

Please mail or email application to current foundation secretary.

*See district directory for current secretary.*