



JASPER LIONS CLUB
P.O. BOX 51
JASPER, IN 47547

Applicant Information

Date: _____

Name: _____
Last First M.I.

Address: _____
Street Address Apartment/Unit #

_____ *City State ZIP Code*

Phone: _____ Email _____

Parent/Guardian Name: _____
Last First M.I.

Address: _____
Street Address Apartment/Unit #

_____ *City State ZIP Code*

Phone: _____ Email _____

Reason Financial Assistance Request

Do you need financial assistance because a provider has provided goods or services? Yes _____ No _____

Is the treatment recommended by a physician, medical clinic, facility or other provider? Yes _____ No _____

If yes, please include documentation. (Letter from physician, prescription, invoice, etc.)

Funding is limited and primarily give to those most in need. If you are not funded, will you proceed with the recommended treatment? Yes _____ No _____

Estimated Cost of Treatment: \$ _____

The undersigned Applicant or Guardian verifies that the information provided in this request for financial assistance is correct and true to the best of the undersigned's knowledge, information and belief.

Signature of Applicant or Guardian: _____ Date: _____

Jasper Lions Club

Signature of Jasper Lions Club Vision Representative: _____ Date: _____

Signature of Jasper Lions Club President: _____ Date: _____