



## SPRINGFIELD NOON LIONS CLUB FOUNDATION (SNLCF) Lions4Sight Program



Applicants must have income at or below the poverty levels shown in the following chart, or current year as determined by the United States Department of Health and Human Services.

Federal Poverty Level (FPL)	
Family size	2024 income
Single	\$15,060
For a family of 2	\$20,440
For a family of 3	\$25,820
For a family of 4	\$31,200
For a family of 5	\$36,580
For a family of 6	\$41,960
For a family of 7	\$47,340
For a family of 8	\$52,720

Proof of income is required, the following documents are acceptable

1. Worker's compensation
2. Page 1 & 2 of Federal tax return
3. W2 income statement
4. 1099
5. Social security statement
6. Proof of income letter
7. Severance statement
8. Court ordered agreement
9. Unemployment statements
10. Disability insurance
11. Pay Stub

The SNLCF only meets once a month for application review, funding is contingent upon application compliance and budget availability. Applicants are eligible once every two years One Pair is provided per applicant every two years (if eligible) unless just cause is presented to the current foundation at the time of the application and approved by a majority vote. A new application is required for each request.

The SNLCF Secretary may request more information after initial review, all SNLCF Board of Directors application review decisions are final.

**SPRINGFIELD NOON LIONS CLUB FOUNDATION**  
**Lions4Sight Application**

PLEASE PRINT (All information must be filled out by applicant, do not leave blank spaces)

**Applicant Information**

Today's Date \_\_\_\_\_

Applicant's Name (parent/guardian if applicant is underage) \_\_\_\_\_

Name of person needing assistance \_\_\_\_\_

Date of Birth \_\_\_\_\_

Address \_\_\_\_\_ Apt \_\_\_\_\_

City \_\_\_\_\_, IL. Zip \_\_\_\_\_

Home Phone# \_\_\_\_\_ Work # \_\_\_\_\_

Sex(M/F/O) \_\_\_\_\_

**Assistance Requested (check mark accordingly)**

Eye Exam \_\_\_\_\_ Eye Glasses \_\_\_\_\_

**Family Information**

Marital Status: \_\_\_\_\_ Number of Dependents \_\_\_\_\_ Ages \_\_\_\_\_

Occupation \_\_\_\_\_

Employer Name \_\_\_\_\_

Address \_\_\_\_\_

Phone # \_\_\_\_\_

Disabled (Y/N) \_\_\_\_\_ Nature of disability \_\_\_\_\_

**\*TOTAL MONTHLY INCOME**

Wages <b>or</b> General Assistance	\$ _____
Pension	\$ _____
Unemployment	\$ _____
Social Security/SSI	\$ _____
Food Stamps	\$ _____
Other	\$ _____

**TOTAL MONTHLY EXPENSES**

Rent/Mortgage	\$ _____
Utilities	\$ _____
Cell phone	\$ _____
Medical	\$ _____
Clothing	\$ _____
Food	\$ _____
Other	\$ _____

**Total** \$ \_\_\_\_\_

**Total** \$ \_\_\_\_\_

Do you have: \_\_\_\_\_ Medical Insurance, Insurance Co. Name: \_\_\_\_\_

**IF YOU HAVE INSURANCE YOU MUST GO THROUGH YOUR INSURANCE PRIOR TO RECEIVING ASSISTANCE FROM LIONS (or provide insurance rejection documentation).**

**Medicaid:** Yes \_\_\_\_\_ No \_\_\_\_\_

The above information is true to the best of my knowledge.

**Applicant's Signature** \_\_\_\_\_

**\*You will be required to provide proof of Income to comply with the Poverty requirement on the previous page**

**Please return to: Springfield Noon Lions, PO Box 5441, Springfield, IL 62705-5441**