

**NORTH CAROLINA LIONS FOUNDATION  
MATCHING FUNDS REQUEST**

**PAGE 1**

**A LIONS CLUB APPROVING REQUEST**

CLUB \_\_\_\_\_ DISTRICT \_\_\_\_\_

—

NAME \_\_\_\_\_ DATE \_\_\_\_\_

ADDRESS \_\_\_\_\_

CITY \_\_\_\_\_ STATE \_\_\_\_\_ ZIP \_\_\_\_\_

DAYTIME PHONE \_\_\_\_\_

IS CLIENT VISUALLY IMPAIRED? YES ☐ NO ☐ VISUAL ACUITY IF KNOWN? \_\_\_\_\_

HAS CLIENT BEEN TO SOCIAL SERVICES FOR ASSISTANCE? YES ☐ NO ☐

I HEREBY CERTIFY THAT TO THE BEST OF MY KNOWLEDGE PUBLIC ASSISTANCE IS NOT AVAILABLE.

SIGNED \_\_\_\_\_ TITLE \_\_\_\_\_

(CLUB OFFICER SIGNATURE REQUIRED)

**B CLIENT INFORMATION**

NAME OF APPLICANT \_\_\_\_\_ AGE \_\_\_\_\_

ADDRESS \_\_\_\_\_

CITY \_\_\_\_\_ STATE \_\_\_\_\_ ZIP \_\_\_\_\_

TELEPHONE \_\_\_\_\_ H \_\_\_\_\_ B \_\_\_\_\_

NAME OF GUARDIAN IF CLIENT IS A  
MINOR \_\_\_\_\_

**C PURPOSE OF REQUEST**

Glasses ☐ Eye Exam ☐ Glasses and Exam ☐ Other (Please explain) ☐

\_\_\_\_\_  
\_\_\_\_\_

EQUIPMENT OVER \$500 REQUIRES A CERTIFICATION LETTER. (See section 5d of Policy)

**D AGENCY OR INDIVIDUAL RECEIVING PAYMENT**

NAME \_\_\_\_\_ DATE \_\_\_\_\_

ADDRESS \_\_\_\_\_

CITY \_\_\_\_\_ STATE \_\_\_\_\_ ZIP \_\_\_\_\_

**INVOICE MUST BE ATTACHED**

**E MATCHING FUND PAYMENT MINIMUM REQUEST \$50 (\$25 CLUB/\$25 NCLF)**

LIST CLUB OR CLUBS OFFERING ASSISTANCE TO THIS CLIENT.

\_\_\_\_\_ AMOUNT \_\_\_\_\_

\_\_\_\_\_ AMOUNT \_\_\_\_\_

MAXIMUM REQUEST: MEDICALLY RELATED SERVICES	\$2,500 (\$1,250 CLUB/\$1,250 NCLF)
OTHER GOODS OR SERVICES	\$1,500 (\$750 CLUB/\$750 NCLF)
HEARING RELATED TREATMENTS	\$ 600 (\$400 CLUB/\$200 NCLF)
EYE EXAM AND GLASSES	\$ 200 (\$100 CLUB/\$100 NCLF)
PROSTHETIC EYE	\$1,200 (\$600 CLUB/\$600 NCLF)

ATTACH CLUB(S) CHECK(S) MADE PAYABLE TO N. C. LIONS FOUNDATION, INC.

IF REQUEST IS \$500 OR MORE (\$250 CLUB/\$250 NCLF) COMPLETE PAGE TWO OF THIS FORM  
PAGE 2 MUST BE COMPLETED IF REQUEST IS \$500 OR MORE (\$250 CLUB/\$250 NCLF)

**F FAMILY INFORMATION** (IF APPLICANT IS A MINOR SHOW INFORMATION FOR PARENTS OR LEGAL GUARDIAN)

CLIENTS EMPLOYER \_\_\_\_\_ POSITION \_\_\_\_\_

SPOUSE EMPLOYER \_\_\_\_\_ POSITION \_\_\_\_\_

**INCOME**

CLIENTS GROSS MONTHLY INCOME \_\_\_\_\_

SPOUSES GROSS MONTHLY INCOME \_\_\_\_\_

WELFARE ASSISTANCE \_\_\_\_\_

OTHER SOURCE OF MONTHLY INCOME \_\_\_\_\_

TOTAL MONTHLY INCOME \_\_\_\_\_

**EXPENSES**

	BALANCE	MONTHLY PAYMENT
--	---------	-----------------

HOUSE PAYMENT OR RENT	_____	_____
-----------------------	-------	-------

CAR PAYMENT	_____	_____
-------------	-------	-------

UTILITIES	_____	_____
-----------	-------	-------

OTHER	_____	_____
-------	-------	-------

**ASSETS**

	VALUE
--	-------

HOUSE	_____
-------	-------

OTHER REAL ESTATE	_____
-------------------	-------

CARS	_____
------	-------

SAVINGS ACCOUNTS	_____
------------------	-------

OTHER INVESTMENTS	_____
-------------------	-------

OTHER	_____
-------	-------

TOTAL	_____
-------	-------

**LIMITS ON MATCHING FUNDS:**

MAXIMUM REQUEST: MEDICALLY RELATED SERVICES	\$2,500 (\$1,250 CLUB/\$1,250 NCLF)
---	-------------------------------------

OTHER GOODS OR SERVICES	\$1,500 (\$750 CLUB/\$750 NCLF)
-------------------------	---------------------------------

HEARING RELATED TREATMENTS	\$ 600 (\$400 CLUB/\$200 NCLF)
----------------------------	--------------------------------

EYE EXAM AND GLASSES	\$ 200 (\$100 CLUB/\$100 NCLF)
----------------------	--------------------------------

PROSTHETIC EYE	\$1,200 (\$600 CLUB/\$600 NCLF)
----------------	---------------------------------

MINIMUM REQUEST\$ 50 (\$25 CLUB/\$25 NCLF)	
--	--

**G FOUNDATION USE ONLY**

APPROVED BY \_\_\_\_\_ DATE \_\_\_\_\_