LightHouse Fund Application

Under the Women's Fund El Dorado

Email or fax saved application and provider invoice to Amy@womensfundeldorado.org or 888.404.6855 or mail to PO Box 1388, Placerville, CA 95667.

Date: _____ Referring Organization/ Provider: _____

Contact Person: _____Email: _____Phone #: _____

Contact Person's Mailing Address: _____

_____

1. Name of person needing assistance.

2. Have you verified the applicant's identification **and** a current address on El Dorado County's Western Slope?

3. What amount are you requesting (up to $500)?

4. What is the nature of the need? Please include relevant background information.

5. What has already been done to address this health need?

6. How will this assistance address the medical, dental, optical, hearing, or mental health need?
   Please attach a copy of the provider invoice or if this is an initial visit attach the provider estimate.

7. Has the client applied for assistance with any other organization for this need? If so, which organizations?

8. Can this be covered by client insurance?

9. Has the client previously applied for LightHouse Funds? If so, please provide details.

As part of the application submittal process, you acknowledge that you have the authority to disclose any Personally Identifiable Information relating to the client.