VISIONS OF VISIONS Application Form

Date of Initial Contact: _____Date of Application:_____

Date Letter of Reference Received:_____ ____Reference Verified: _____

NAME:_____Date of Birth: _____

ADDRESS:_____Phone #_____

CITY:_____STATE_____ZIP_____

STATEMENT OF NEED:

_____
_____
_____

HOUSEHOLD SOURCES OF INCOME **LIST PEOPLE LIVING IN HOME & AGES:**

_____
_____
_____
_____

Do you have eye care insurance? Yes/No Do you have other resources to pay for glasses? Yes/No

Do you have Medicare coverage? Yes/No Do you receive Medicaid Assistance? Yes/No

When was last eye exam?_____ When was lenses last replaced?_____

LIST OTHER INFORMATION THAT WILL HELP US IN MAKING A DECISION (ie: single Mom; minimum wage)?

_____
_____
_____

Below is for CEC Board Use Only

BOARD COMMITTEE MEMBERS APPROVED:

1._____ Date: _____

2._____ Date: _____