VISIONS OF VISIONS Application Form

(Please Attach A Letter Of Referral)

Date of Initial Contact: _____ Date of Application:_____ Date of Birth_____

NAME:_____HOME #: _____

ADDRESS:_____ALTERNATE#_____

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)?

_____

_____

_____

If approved, which day is best for your eye exam appointment? Tuesday 5-7pm Thursday 5-7pm

Below is for CEC Board Use Only

Date Letter of Reference Received: _____ Reference Verified: _____

BOARD COMMITTEE MEMBERS APPROVED:

1._____2._____

3._____4._____

Appointment: Doctor: _____ Date:_____ Time:_____