

SIGHT ASSISTANCE REQUEST FORM (ONE PAIR PER YEAR)

Please complete the following information accurately to help the sight conservation committee in considering this request for assistance. All information is confidential.

Assistance requested for: Age:

Address: Phone Number:

City State: Zip Code:

Nature of sight problem:

Family situation (married, divorced, separated, single parent):

Monthly Income:

Income source(s) (Soc. Sec., SSI, Food Stamps, Child support, etc.):

Insurance (Medicare/Medicade, etc.):

Major expenses (rent, utilities, phone, car payment, etc.):

All information must be filled out completely or this request will be designated as VOID.

This request is for people who truly do not have the means to obtain eye glasses.

The Gift Of Sight program will only provide eye care to those under severe financial restrictions. The Gift Of Sight program reserves the right to refuse assistance to anyone who does not meet the strict requirements of the program.

I DO HEREBY CERTIFY THAT ALL OF THE INFORMATION I HAVE PROVIDED ABOVE IS TRUE AND CORRECT AND I HAVE ANSWERED ALL QUESTIONS TO THE BEST OF MY ABILITY.

Application completed by (N/A if same as above):

Relationship: Phone:

Signature: Date:

Additional Comments:

For Committee Use Only

Date Reviewed:

Tax ID#

Approved: YES NO

Appointment with doctor:

Appointment with LensCrafters