

## Application for Sight Assistance

Referring Agency:

Contact: \_\_\_\_\_ Phone: \_\_\_\_\_

*(Application must be filled out completely. Please print clearly)*

Date \_\_\_\_/\_\_\_\_/\_\_\_\_

Name of Applicant \_\_\_\_\_

Address/PO Box \_\_\_\_\_  
Street City State Zip

Phone (\_\_\_\_) \_\_\_\_\_

Own home: \_\_\_\_\_ Rent: \_\_\_\_\_ Live with others: \_\_\_\_\_

Please give specific directions to your home: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Married: \_\_\_\_\_ Single: \_\_\_\_\_ Widowed: \_\_\_\_\_ Divorced: \_\_\_\_\_ Separated: \_\_\_\_\_

Age: \_\_\_\_\_ Sex: \_\_\_\_\_ # of Dependent children: \_\_\_\_\_ Ages: \_\_\_\_\_

### FINANCIAL INFORMATION

*All information is confidential and will not be shared with any other agency or person*

Employer: \_\_\_\_\_ Phone: (\_\_\_\_) \_\_\_\_\_ Salary\$: \_\_\_\_\_

Welfare\$: \_\_\_\_\_ Social Security\$: \_\_\_\_\_ Alimony\$ \_\_\_\_\_

Other Income: \_\_\_\_\_ Source \_\_\_\_\_

Monthly Mortgage/Rental Payment \_\_\_\_\_

*--- On the other side of this application, please state why you need assistance. ---*

Signature of Applicant: \_\_\_\_\_

Sight Committee \_\_\_\_\_ Approved/Disapproved Date: \_\_\_\_\_