EYE CARE APPLICATION

LACKAWANNA BLIND ASSOCIATION
228 ADAMS AVENUE, SCRANTON, PA 18503
PHONE: (570)342-7613, EXT. 5

Name: _____ Date: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone Number: _____ Birthday: _____

1. Are you on (please select below):
   □ Medical Assistance □ Medicare □ Other

2. If presently employed, employees name and address _____

_____

3. Can family pay for the eye exam? Yes_____ No_____
4. Does applicant have glasses now? Yes_____ No_____
5. Does applicant have a current prescription? Yes _____ No_____
6. Who is the applicant referred by? _____

This service is available once a year, unless your prescription changes. The program does not cover transition, progressive lenses, arc, special coating, metal frames, tinting, or sunglasses.

MONTHLY INCOME FROM ALL SOURCES	MONTHLY EXPENDITURES
Wages(gross): $_____	Rent: $_____
Social Security: $_____	Mortgage: $_____
Supplemental Security Income (**SSI**)$_____	Utilities: $_____
Other: $_____	Other: $_____
Total Income: $_____	Total: $_____

_____I ACKNOWLEDGE THE INFORMATION REGARDING FINANCES AND NEED FOR EYE CARE IS COMPLETE AND MAY FURTHER BE VERIFIED BY A REPRESENTATIVE OF THE LASSOCIATION IF NECESSARY TO PROVE ELIGIBILITY FOR THIS SERVICE. ALL INFORMATION SUBMITTED IS CONFIDENTIAL.

$30.00 fee is non-refundable after order is placed

Signature _____ Date_____