

EYE CARE APPLICATION

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

Name: _____ Birthday: _____

Address: _____

_____ Phone Number: _____

Are you on:

- Medical Assistance
- Medicare
- Other

If presently employed, employees name and address: _____

Can family pay for eye exam? _____

Does applicant have glasses now? _____

Referred by? _____

Our program does not cover transition, progressive lenses, arc, special coating, metal frames, tinting, or sunglasses.

MONTHLY INCOME FROM ALL SOURCES

MONTHLY EXPENDITURES

Wages(gross) - \$ _____

Social Security - \$ _____

SSI - \$ _____

Other - \$ _____

Total Income - \$ _____

Rent - \$ _____

Mortgage - \$ _____

Utilities - \$ _____

Other - \$ _____

Total - \$ _____

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

\$45.00 fee is non-refundable after order is placed

Signature _____ Date _____