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
□ Medicaid
□ Medicare
□ Blue Chip Program
□ Social Security

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) - $_____	Rent - $_____
Social Security - $_____	Mortgage - $_____
SSI - $_____	Utilities - $_____
Other - $_____	Other - $_____
Total Income - $_____	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.

$30.00 fee is non-refundable after order is placed

Signature _____ Date_____