

APPLICATION FOR VISION USA SERVICES

Call toll-free (800) 766-4466 for assistance.

****IMPORTANT: PLEASE READ ELIGIBILITY REQUIREMENTS BEFORE FILLING OUT APPLICATION****

"ALL" PROGRAM ELIGIBILITY REQUIREMENTS MUST BE MET

VISION USA PROGRAM ELIGIBILITY REQUIREMENTS

The following states (Arizona, California, Colorado, Hawaii, Kansas, Kentucky, Minnesota, Montana, North Dakota, Wisconsin and Wyoming) participate in VISION USA using a local screening agency. Please refer to <http://www.aoa.org/x5608.xml> for instructions on how to apply in these states.

1. Must be a US citizen or legal resident with a social security or legal resident number
2. Have no private or government insurance, Medicare or Medicaid
3. Have not had an eye exam within the past 24 months
4. Have an income below established guidelines based on household size
5. Have not received a doctor referral through the VISION USA program in the past two years

Section 1. Applicant / Guardian Information

First Name	Last Name	<input type="checkbox"/> U.S. Citizen		<input type="checkbox"/> Legal Resident	
How many people live at this address?	Home Phone: Area Code + Number REQUIRED	Cell Phone: Area Code + Number	Other Phone: Area Code + Number		
How long have you lived at this address?	Email address				
Street Address: Number, Street, Apt. or Lot Number		City	State	Zip Code	
Mailing Address (if different): P. O. Box, Number, Street, Apt. or Lot Number		City	State	Zip Code	
Current or Last Employer Name, City and State					

Section 2. Income Worksheet - VERIFICATION OF INCOME IS REQUIRED *Include income from all members of the household*

Name	Monthly Employment Income, Severance or Unemployment	Monthly Child / Spousal Support	Monthly Social Security, SSI or Disability	Monthly Retirement Income or Workers Compensation	Other Monthly Income (Food Stamps, AFDC, Etc.)	Total
	\$	\$	\$	\$	\$	\$
	\$	\$	\$	\$	\$	\$
Total Approximate Monthly Income (Sum of All Columns Above) REQUIRED						\$

Section 3. Household Members - MUST INCLUDE ALL THOSE APPLYING FOR VISION SERVICES *Maximum of 4 per household per year*

First and Last Name	Birth Date (MM/DD/YYYY)	Gender	Last 4 Digits of Social Security or Legal Resident Number	Ethnicity Category (See Below*)	Relationship to Applicant	Have you had an eye exam in the last 2 years?	Covered by Private or Government Insurance, Medicare or Medicaid	Currently Wears Glasses
EXAMPLE: Susan Smith	12/09/1968	F	5555	W	Applicant	No	No	No
1.					Applicant			
2.								
3.								
4.								

*Ethnicity: (A) Asian, (AA) Black or African American, (H) Hispanic, (M) Multiracial, (NA) American Indian/Alaska Native, (O) Other/Unspecified, (PA) Native Hawaiian / Other Pacific Islander, (W) White

Section 4. Additional Applicant Information

Has the applicant(s) received a doctor referral through the VISION USA program in the past two years? No <input type="checkbox"/> Yes <input type="checkbox"/> If yes, please provide month / year ____ / ____
Name of current eye doctor:

Section 5. Signature

I certify that all information on my application is true and complete to the best of my knowledge and any misrepresentations may result in automatic termination and suspension from making future applications. I give permission for information contained herein to be collected for statistical purposes and understand that patient information will be held in the strictest confidence and will not be shared with other entities.

Applicant / Guardian Signature

Date

Application to be mailed to: **VISION USA, 243 N. Lindberg Blvd., St. Louis, MO 63141** or Faxed to **(314) 991-4101** or emailed to **VisionUSA@AOA.org**

PLEASE PRINT NEATLY: INCOMPLETE OR ILLEGIBLE APPLICATIONS WILL NOT BE PROCESSED



The AOA Foundation
VISION USA
 Volunteers In Service In Our Nation

Dear Applicant:

Attached is your application for a free basic eye health and vision exam through the VISION USA program. The program has instituted new rules and now requires income verification.

Proof of income is required for total income for each member of the household from any of the sources listed below:

- | | | |
|------------------|--------------------|---------------------------|
| 1. Employment | 5. Social Security | 9. AFDC |
| 2. Severance | 6. SSI | 10. Worker's Compensation |
| 3. Unemployment | 7. Disability | 11. Food Stamps |
| 4. Child Support | 8. Retirement | 12. Other |

YOU MUST PROVIDE PROOF OF INCOME.

(Example: Last 2 Employment Check Stubs, Checking Account Statement, W-2, 1099, SSI, Disability, Food Stamp Documents, Letter from Social Workers, Etc.)

Even if the answer to the income question is zero, we need to understand your circumstances. Are you living in a shelter or with friends? Have you applied for assistance and been turned down or has your unemployment benefits run out? If this is the case, please include a copy of the paperwork you received and provide a brief explanation of resources that are helping your household.

2012 INCOME LEVEL NOT TO EXCEED BY HOUSEHOLD SIZE

	1 Person	2 People	3 People	4 People	5 People	6 People	7 People	8 People	9 People	9+
Annual	\$16,755	\$22,695	\$28,635	\$34,575	\$40,515	\$46,455	\$52,395	\$58,335	\$64,275	\$70,215
Monthly	\$1,396	\$1,891	\$2,386	\$2,881	\$3,376	\$3,871	\$4,366	\$4,861	\$5,356	\$5,851

DO NOT SEND ORIGINALS – COPIES ONLY PLEASE!

Documents will be shredded upon completion of application processing.

Please blacken out confidential information such as Social Security or bank account numbers.

Please review application for completeness. Then sign the bottom of the application and return along with copies of proof of income to:

VISION USA
243 N LINDBERG BLVD
ST LOUIS, MO 63141
FAX: 314-991-4101 or EMAIL: VISIONUSA@AOA.ORG

PLEASE ALLOW 3-5 WEEKS FOR APPLICATION PROCESSING