

VISION USA PATIENT APPLICATION FORM

**May be used for all family members. You may make copies if you need more forms.
Applications are accepted year round.**

VISION USA provides free eye exams to eligible, low-income working families. Services are donated by volunteer optometrists who are members of the American Optometric Association and may be limited in some areas.

COMPLETE THIS APPLICATION FORM ONLY IF:

1. The person seeking care has no public or private insurance that covers eye exams;
2. The person has not had an eye exam in the last 2 years;
3. The household is low-income and unable to pay for eye exams.

NO EXCEPTIONS WILL BE MADE

You may also apply by telephone toll-free at (800) 766-4466.

You must answer all information and questions. Verification may be requested. Please print legibly.

1. Is at least one person in your household currently working? (Either full-time, part-time, or both) (✓) Yes No
2. What is the total number of people in your household living with you including yourself? _____
3. What was your household's approximate gross income (before taxes and deductions) including income from other sources such as alimony and child support?

Last Year \$ _____
 OR **(not both)**
 Last Month \$ _____

(write in dollars only)

Please PRINT the names of the members of your household you want to apply for a free eye exam.

First Name	Last Name	Has this person had an eye exam in the last two years? (School screenings are NOT considered an exam.)	Does this person have any private or government insurance, Medicaid or Medicare, that covers eye exams?
1.		<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
2.		<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
3.		<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
4.		<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
5.		<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
6.		<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No

Address _____ Apt. _____

City _____ State _____ Zip _____

Daytime Telephone Number () _____

Please allow 4 to 8 weeks. If you are qualified and a volunteer doctor is available in your area, a letter will be mailed to you with the doctor's name and further instructions.

Return to: VISION USA, 243 N. Lindbergh Blvd., St. Louis, MO 63141-7881 or FAX: (314) 991-4101.