

**REQUEST FOR ASSISTANCE WITH EYE EXAM AND/OR GLASSES**



**Date Sent:** \_\_\_\_ / \_\_\_\_ / \_\_\_\_

**Name:** \_\_\_\_\_ **Contact:** \_\_\_\_\_

**Date of Birth:** \_\_\_\_ / \_\_\_\_ / \_\_\_\_ **Phone:** \_\_\_\_\_

**Address:** \_\_\_\_\_

\_\_\_\_\_  
**(City)** / \_\_\_\_\_ **(Zip Code)** **County:** \_\_\_\_\_

**Ethnic Background:**  Caucasian  African-American  Hispanic  Asian  Other \_\_\_\_\_

**Highest Level of Completed Education:**  K-8  9-12  HS/GED  Some College  Degree

**QUESTIONS:**

1. Symptoms indicating need for eye examination and/or glasses: \_\_\_\_\_

\_\_\_\_\_

2. Do you have any government or private insurance, even if it does not cover eye examinations? No / Yes  
 Medicare  Medicaid  Wishard Advantage  BC/BS  Private  Other \_\_\_\_\_

3. Medical conditions that may relate to your vision problem: \_\_\_\_\_  
 Diabetes  Hypertension/High Blood Pressure  Glaucoma  Cataract  AMD  Retinopathy

4. Date of your last professional eye examination (Optometrist or Ophthalmologist): \_\_\_\_\_

5. Are you or any other member of the household currently employed? Yes / No If yes, Full Time / Part Time  
Wages \$ \_\_\_\_\_ Food Stamps \$ \_\_\_\_\_ Disability \$ \_\_\_\_\_ SSI \$ \_\_\_\_\_ Pension \$ \_\_\_\_\_ Other \$ \_\_\_\_\_

6. Total Annual Household Income: \$ \_\_\_\_\_ 7. Number in Household: \_\_\_\_\_

<b>Referred From:</b>	
<b>Organization:</b>	
<b>Address:</b>	
<b>City, State, Zip:</b>	
<b>Phone Number:</b>	
<b>Email:</b>	

<i>Send this form to:</i> <b>Gift of Vision</b> <b>70 E. 91<sup>st</sup> St., Suite 204</b> <b>Indianapolis, IN 46240</b> <b>Fax: 317-815-9952</b> <b>Phone: 317-815-9943 x 226</b>
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*This form is used to determine qualification for Gift of Vision services—information is kept confidential and the statistics gathered will help track the need for vision care services throughout the state of Indiana.*