Financial Assistance Form

1. Date	2. Completed by

Part I: PERSONAL INFORMATION

3. Name		
4. Address 1	5. Address 2	
6. City	7. State	8. Zip

9. Phone 1 ( )	10. Type Home Cell Work
11. Phone 2 ( )	12. Type Home Cell Work

13. Date of Birth	14. Age
15. Ethnicity	

Emergency Contact

16. Name	17. Relationship
18. Phone 1 ( )	19. Type Home Cell Work
20. Phone 2 ( )	21. Type Home Cell Work

Part II: ELIGIBILITY

You must meet all the following criteria to be eligible for Financial Assistance.

- ☐ 22. You are uninsured; or your insurance does not cover vision rehabilitation services
- ☐ 23. You are blind or visually impaired
- ☐ 24. You are determined to be unable to pay for services provided
- ☐ 25. You are unable to accept an installment payment arrangement due to lack of income

Part III: FINANCIAL INFORMATION

26. Number in Household:	27. Monthly Income:

Supplemental Income		Documentation Needed
28. SSDI	$	33. A copy of your last two pay check stubs
29. Retirement Pension	$	34. Current year Federal 1040 tax return
30. Veteran's Pension	$	35. Unemployment benefits (check stubs)
31. Supplemental Security	$	36. Social Security benefits (copy of check/letter from SSA)
32. Other	$	37. SRS grants and/or amount of food assistance

Part IV: VISION LOSS

When applying for Financial Assistance for a **Low Vision Evaluation** the following must be completed by a Physician or accompanied by current documentation from a Physician.

38. Onset of vision loss (date)	39. Diagnosis
40. Optics/Aids Used	
41. Other Medical Concerns	

42. Current Optometrist/Ophthalmologist

Part V: REHABILITATION SERVICES

Please check all Services that you are Seeking or are Currently Receiving:

	Seeking	Have
43. Low Vision Evaluation		
44. OT Evaluation & Treatment		
45. Orientation & Mobility (O&M)		
46. Assistive Technology		
47. Other:		
48. Other:		

Have you sought other Funding Sources for what you are applying for? Yes or No

49. If so, what source?
50. What was the outcome?

Part VI: MISCELLANEOUS

Are you interested in information about Support Groups? Yes or No

51. If yes, what types of activities would you be interested in?

Are you interested in Employment at Envision? Yes or No

52. If yes, what types of position(s) would you be interested in?

Are you interested in Volunteering at Envision? Yes or No

53. If yes, what types of position(s) would you be interested in?

Part VII: DISCLOSURE

The Envision Low Vision Rehabilitation Center will not discriminate based on race, color, religion, gender, national origin, ancestry, veteran status, age, disability, or any other legally protected characteristics.

Completion of this form does not guarantee eligibility for Financial Assistance. Incomplete or inaccurate information may cause delay or cancellation of your application. Eligibility will be reviewed every six months. At your request you will have the opportunity to discuss the application or outcome with a staff member.

To the best of my knowledge, all of the information included on this form is accurate.

Patient Signature: **Date:**

(Or representative in the event the patient is under the age of 18 or unable to sign)