Eye Care Assistance Application

NORTH CENTRAL SIGHT SERVICES INC.

Member of Pennsylvania Association for the Blind
ROBERT B. GARRETT
PRESIDENT/C.E.O.

HAVE YOU UTILIZED THIS PROGRAM BEFORE? ☐ YES ☐ NO

Reimbursement Will Not Be Provided For Glasses Ordered Without Agency Authorization

TODAY'S DATE _____

SERVICE REQUESTED: ☐ Eye exam ☐ Glasses

FULL NAME _____ GENDER _____ PHONE _____

DATE OF BIRTH _____ PARENT'S NAME (IF UNDER AGE 18) _____

STREET ADDRESS _____ CITY, STATE, ZIP, COUNTY _____

REFERRED BY _____ CHILD'S SCHOOL (IF APPLICABLE) _____

Current Insurance: ☐AmeriHealth ☐Coventry ☐Geisinger ☐ACCESS ☐Medicare ☐None ☐Other: _____

DATE OF YOUR LAST EYE EXAM AND PROVIDER NAME: _____

DO YOU HAVE? ☐ Diabetes ☐ Glaucoma ☐ Cataracts ☐ Macular Degeneration ☐ Low Vision

HOUSEHOLD MONTHLY INCOME (attach copies of income sources, i.e. payroll stub, soc. security statement, etc.)

Please list **ALL** members of your household even if they do not have an income, as well as **ALL** sources of income.
(examples: wages, food stamps, child support, SSI, SSDI,...)

HOUSEHOLD MEMBER NAME	RELATIONSHIP	SOURCE OF INCOME	AMOUNT	FORM?
			$	
			$	
			$	
			$	
			$	
			$	
TOTAL GROSS *MONTHLY* HOUSEHOLD INCOME:			$	
			x 12	
		YEARLY INCOME:	$	

I certify, to the best of my knowledge, that the information that I provided here is true, correct and complete.

SIGNATURE OF PARENT OR GUARDIAN _____ DATE _____

PAYMENT MUST BE PAID IN FULL TO NORTH CENTRAL SIGHT SERVICES BEFORE GLASSES ARE ORDERED