The AOA Foundation
VISION USA
Volunteers In Service In Our Nation

# 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<br>2. Have no private or government insurance, Medicare or Medicaid<br>3. Have not had an eye exam within the past 24 months<br>4. Have an income below established guidelines based on household size<br>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 | ☐ U.S. Citizen | ☐ 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 | Date of Last Eye Exam | Covered by Private or Government Insurance, Medicare or Medicaid | Currently Wears Glasses |
|---|---|---|---|---|---|---|---|---|
| EXAMPLE: Susan Smith | 12/09/1968 | F | 5555 | W | Applicant | 10/2009 | 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 ☐ Yes ☐ 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 63141or Faxed to (314) 991-4101 or emailed to VisionUSA@AOA.org**

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

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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.

**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

**PLEASE NOTE: A CONTACT EXAM AND / OR CONTACT LENSES ARE NOT AVAILABLE THROUGH THIS PROGRAM.**