# APPLICATION WORKSHEET FOR VISION USA SERVICES

The AOA Foundation
VISION USA

## Applicant Instructions

_____Fill out application below.

_____Locate and contact a social service agency. When scheduling your appointment with the agency, explain that you are in need of their assistance in submitting the application.

_____Bring application, identification and proof of income documents with you.

_____Social service agent will submit application and state will respond.
(A contact lens exam and / or contacts are not available through this program.)
*This application **must** be submitted to your state's coordinator by a social service agency..*

_____Retain a copy of this application for your records.

### If you are assigned an appointment

_____You are responsible for your own transportation and must be on time for your appointment to avoid scheduling conflicts.

_____Contact the doctor's office 48 hours in advance of the day of your appointment should you need to cancel or reschedule.

_____Missed appointments will not be rescheduled and will further disqualify you from receiving free eye care. Appointment days and times are limited.

Proof of income is required for total income for each member of the household from all sources listed below:

| | |
|---|---|
| 1. Employment | $_____ |
| 2. Severance | $_____ |
| 3. Unemployment | $_____ |
| 4. Child Support | $_____ |
| 5. Social Security | $_____ |
| 6. SSI | $_____ |
| 7. Disability | $_____ |
| 8. Retirement | $_____ |
| 9. AFDC | $_____ |
| 10. Worker's Comp | $_____ |
| 11. Food Stamps | $_____ |
| 12. Other | $_____ |
| Total | $_____ |

## Please Read Eligibility Requirements Before Completing Application Worksheet
"All" Program Eligibility Requirements must be met

### VISION USA PROGRAM ELIGIBILITY REQUIREMENTS

1. Must be a US citizen or legal resident with a social security or legal resident number
2. Have no private or government insurance, Medicare or Medicaid
3. Have not had an eye exam within the past 24 months
4. Have an income below established guidelines based on household size* (*see chart below*)
5. Have not received a doctor referral through the VISION USA program in the past two years
6. Maximum of 4 applicants per household per year

To ensure you are meeting your state's requirements, or to find out where and how to submit your application, please visit our website at www.aoa.org/visionusa.

### Section 1. Applicant Information **ALL INFORMATION IN THIS SECTION IS REQUIRED**

| First Name | Last Name | Phone Number: Area Code + Number | Other Phone: Area Code + Number |
|---|---|---|---|
| | | ( ) | ( ) |

| Street Address: Number, Street, Apt. or Lot Number | City | State | Zip Code |
|---|---|---|---|
| | | | |

| Birth Date (MM/DD/YYYY) | Gender | Last 4 Digits of Social Security or Legal Resident Number REQUIRED |
|---|---|---|
| / / | _____ Male _____ Female | |
| Ethnicity Category (See Below*) | Have you had an eye exam in the last 2 years? _____ No _____ Yes (if yes, not eligible) | Covered by Private or Government Insurance, Medicare or Medicaid _____ No _____ Yes (if yes, not eligible even if eye care is not covered) |

**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 2. Income Worksheet - VERIFICATION OF INCOME IS REQUIRED *Include income from all members of household*

| 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 REQUIRED | |
| | | | | How many people live in the household? REQUIRED | |

**VERIFY INCOME ELIGIBILITY USING THE CHART BELOW. MUST BE "AT OR BELOW" THE AMOUNT SHOWN FOR THE NUMBER OF PEOPLE LIVING IN THE HOUSEHOLD.*

| Income Level | 1 Person | 2 People | 3 People | 4 People | 5 People | 6 People | 7 People | 8 People | 9 People | 9+ |
|---|---|---|---|---|---|---|---|---|---|---|
| Annual | $24,120 | $32,480 | $40,840 | $49,200 | $57,560 | $65,920 | $74,280 | $82,640 | $91,000 | $99,360 |
| Monthly | $2,010 | $2,707 | $3,403 | $4,100 | $4,797 | $5,493 | $6,190 | $6,887 | $7,583 | $8,280 |

### Section 3. Additional Applicant Information

Has the applicant received a doctor referral through the VISION USA program in the past two years? No ☐ Yes ☐ If yes, not eligible

### Section 4. 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 |
|---|---|
| | |

Visit our Website www.aoa.org/visionusa to find out where to send your application

Eyewear may be provided at no cost or for a small fee/donation in some states. Doctors donate their services and are limited in some areas.

Referral agency instructions on reverse side

The AOA Foundation
VISION USA

## Social Service Agency's Instructions

VISION USA provides a basic eye examination to low-income US citizens or legal residents. Member doctors of the American Optometric Association donate services. Eyewear may be provided at no cost or for a small fee/donation in some states.

****IMPORTANT: APPLICATIONS MUST BE SUBMITTED BY A SOCIAL SERVICE AGENCY****

If you are an individual or referral agency that is not yet registered with the program, visit www.aoa.org/visionusa to learn how to apply.

### Section 1. Social Service Agent Contact Information

| First Name | Last Name | Agency Phone: Area Code + Number | Other Phone: Area Code + Number |
|---|---|---|---|
| | | ( ) | ( ) |
| Agency Name (Agency / organization will be verified) | | | |
| Agency Street Address: Number, Street, Suite, Room, Floor, Etc. | | City | State Zip Code |
| Email address **REQUIRED** -- All followup contact will be sent via email to agency | | | |

To qualify, applicants must meet all five of the eligibility requirements. Verify eligibility requirements below BEFORE submitting application:

**ELIGIBILITY REQUIREMENTS**

| | | | |
|---|---|---|---|
| 1. | Does applicant have private or government insurance, Medicare or Medicaid? | Yes _____ | No _____ |
| 2. | Does applicant have income higher than the established level based on household size?* | Yes _____ | No _____ |
| 3. | Has applicant had an eye exam in the past 24 months? | Yes _____ | No _____ |
| 4. | Is the applicant unable to provide a social security or legal US resident number? | Yes _____ | No _____ |
| 5. | Has applicant received a doctor referral through the VISION USA program in the last two years? | Yes _____ | No _____ |

**IF "YES" IS ANSWERED TO ANY OF THE QUESTIONS ABOVE, APPLICANT IS NOT ELIGIBLE FOR SERVICES. DO NOT SUBMIT AN APPLICATION.**

***INCOME LEVELS - MUST BE "AT OR BELOW" THE AMOUNT SHOWN FOR THE NUMBER OF PEOPLE LIVING IN THE HOUSEHOLD.**

| Income Level | 1 Person | 2 People | 3 People | 4 People | 5 People | 6 People | 7 People | 8 People | 9 People | 9+ |
|---|---|---|---|---|---|---|---|---|---|---|
| Annual | $24,120 | $32,480 | $40,840 | $49,200 | $57,560 | $65,920 | $74,280 | $82,640 | $91,000 | $99,360 |
| Monthly | $2,010 | $2,707 | $3,403 | $4,100 | $4,797 | $5,493 | $6,190 | $6,887 | $7,583 | $8,280 |

**AGENCY INSTRUCTIONS**

_____Receive completed application worksheet from client (or work with client to complete).

_____Verify applicant meets "all" eligibility requirements, including review of proof of income documents.

_____Submit application to your specific state following instructions at www.aoa.org/visionusa

_____Your state's program coordinator will follow up with next steps and additional information.

_____Retain a copy of the application worksheet and communications for future reference.

Clients Name_____ Date Application Submitted _____

Applicant instructions on reverse sid