Financial Assistance Application

Phone: 330-750-1867; Fax 330-750-1562
966 Fifth Street, Struthers, OH 44471
sightforall2016@gmail.com

APPLICANT INFORMATION

Who referred you/ Eye Doctor			
Applicant's Name		Social Security #	
Address	City	St	Zip
Date of Birth/Age:	Marital Status	How many in Household	
Day Phone	Cell Phone	Email	

RESPONSIBLE PARTY IF APPLICANT IS A DEPENDENT

Name:	Social Security #:	
Email Address:	Cell Phone #	
Home Phone #:	Work Phone#:	
Address:	City/State:	Zip:
Relationship to Applicant:		

FINANCIAL INFORMATION FOR APPLICANT/RESPONSIBLE PARTY

MONTHLY INCOME (GROSS)	MONTHLY EXPENSES
Salary	Circle Mortgage or Rent $
Retirement/Pension	House Insurance $
Social Security	House Taxes $
General Relief	Medical
Unemployment	Loans
Direction Card	Food
Workmen's Comp.	Life/Health Insurance
Alimony/Child Support	Gas
Investments/Ira/401k	Electric
Retirement	Water
Checking Account Balance	Phone
Savings Account Balance	Car Insurance
Other	Other
TOTAL INCOME	Please Include Proof of All Expenses **TOTAL EXPENSES**

Are you on SSI benefit(s) ____ If so, which programs_____

Have you ever applied for SSI benefit(s)_____ Are you disabled? _____

Are you a Veteran? _____

Explain eye condition and services needed:

_____

_____

_____

INSURANCE PROVIDER INFORMATION
HEALTH INSURANCE PROVIDER:
POLICY OR GROUP NUMBER:
ADDRESS OF PROVIDER:
PHONE NUMBER OF PROVIDER:

Other information:

_____

_____

Please include most recent tax return. If you do not file taxes, please explain:

_____ If no

Tax Return, please provide proof of income using one or more of the following:

☐ Social Security (SSI) Benefit Letter ☐ Most Recent W2's

☐ 3 months all Bank Statements ☐ Other Proof of Income

In consideration of your acceptance of this application form, I hereby for myself, my administrators, my heirs and assigns, waive and release all rights and claims for damages I have against the organizers of this event, their associates and representatives. Completion of the application does not guarantee assistance. I certify that the above financial information is correct to the best of my knowledge. I hereby authorize Sight for All United to obtain all information concerning my health insurance. Sight for All United is not responsible or liable for satisfaction of services and/or quality of outcome.

Signature_____ Date_____

Parent or Guardian_____ Date_____

I agree and give permission that my name, photo and assistance I receive can be published and distributed to help benefit others looking for assistance.

Signature_____ Date_____