Application for LensCrafters Gift of Sight Program

NOTE: The Arc Upper Valley is a referring agency for the Lenscrafters Gift of Sight Program. Referrals can only be made for individuals residing in our service area, which is the upper eastern portion of North Dakota. If you are outside our service area, your application will not be acknowledged. Contact your local Lenscrafters store for a list of referring agencies in your area.

The Arc Upper Valley

Send completed application to:

Gift of Sight Program
c/o The Arc, Upper Valley
2500 DeMers Ave
Grand Forks ND 58201
(701) 772-6191

APPLICANT

NAME: _____ PHONE: _____

ADDRESS: _____ CITY: _____

STATE: _____ ZIP CODE: _____ COUNTY: _____

DATE OF BIRTH _____

MARITAL STATUS: (check one) ____SINGLE ____MARRIED ____DIVORCED ____WIDOWED

NUMBER OF PEOPLE IN APPLICANT'S HOUSEHOLD: _____

NAME OF ADDITIONAL PERSON(S)	AGE	RELATIONSHIP TO APPLICANT
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

FINANCIAL INFORMATION

ARE YOU EMPLOYED?: ____YES ____NO MONTHLY WAGE: $_____

IS YOUR SPOUSE EMPLOYED?: ____YES ____NO SPOUSE'S MONTHLY WAGE: $_____

OTHER MONTHLY INCOME $_____ SOURCE _____

DO YOU HAVE MEDICAL INSURANCE (OTHER THAN MEDICARE OR MEDICAID)?: ____YES ____NO

REFERRING AGENCY (IF ANY)

AGENCY NAME _____ PHONE _____

CASEWORKER _____ ADDRESS _____

CITY _____ STATE _____ ZIP CODE

PROGRAM STIPULATIONS

1. RECIPIENT IS RESPONSIBLE FOR THE EYE EXAM FEE OF $40.

2. RECIPIENT IS RESPONSIBLE FOR TRAVEL TO AND FROM APPOINTMENTS, WHICH WILL TAKE PLACE AT LENSCRAFTERS IN FARGO, ND.

3. RECIPIENT WILL RECIEVE ONE PAIR OF FREE EYEGLASSES.
   (LIMITED TO THE STYLES AND COLORS AVAILABLE).
   FREE EYEGLASSES CANNOT BE TINTED OR MADE INTO SUNGLASSES.

4. IF EYEGLASSES ARE BROKEN OR LENSES SCRATCHED, THEY CANNOT BE REPLACED WITHOUT ANOTHER REFERRAL.

5. THIS PROGRAM IS NOT DESIGNED FOR PERSONS WHO HAVE HAD OR ARE HAVING LASIK SURGERY.

6. LENSCRAFTERS HAS THE RIGHT TO DECLINE ANY RECIPIENT IF THEY HAVE MIS-STATED INFORMATION ON THIS APPLICATION OR ARE NOT ABIDING BY PROGRAM RULES.

To the best of my knowledge, the information provided on this form is a full and accurate disclosure of my current financial status. I understand and agree to the above stated stipulations of LensCrafters Gift of Sight Program.

_____ Date _____
Signature of applicant

_____ Date _____
Signature of parent or guardian (if applicable)

_____ Date _____
Signature of caseworker (if applicable)

OFFICE USE ONLY - DO NOT WRITE BELOW THIS LINE