

Sight for Sight Assistance Program

Application for Financial Assistance

Instructions: This application must be completed at a licensed optometry or ophthalmology facility and submitted to Finney County United Way (FCUW) by facility staff. Applications are accepted at any time and will be payable to the medical facility. Funds will be released within 2 weeks of receiving the application. All information will be kept confidential.

1. Applicant Information

Applicant Name: _____

Date of Birth: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone Number: _____

Email (if available): _____

County of Residence: _____

2. Household Information

Total Number of People in Household: _____

Total Annual Household Income: \$_____

Income Verification Attached: Yes No

3. Requested Vision Services

- Eye examination
- Corrective lenses / Glasses
- Eye surgery
- Treatment for eye injury
- Other (please describe): _____

Brief description of need:

Total Cost of Services: \$_____

Amount Requested (not to exceed \$5,000 per calendar year): \$_____

4. Insurance / Other Assistance

Do you have vision insurance? Yes No

If yes, amount insurance will cover: \$ _____

Have you applied for other financial assistance? Yes No

If yes, amount received or pending: \$ _____

5. Applicant Certification

I certify that the information provided is true and accurate to the best of my knowledge. I understand that funding is subject to eligibility requirements, available funds, and program guidelines. I authorize the release of necessary information to Finney County United Way and Sight for Sight for the purpose of determining eligibility.

Applicant Signature: _____ Date: _____

6. Facility Verification (To Be Completed by Provider)

Facility Name: _____

Provider Name: _____

Provider Signature: _____

Date Submitted to FCUW: _____