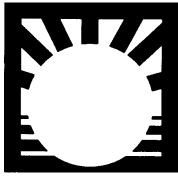

PROJECT EYE CARE APPLICATION

Application Fee$30.00

Saving Sight Rhode Island
982 West Shore Road
Warwick, RI 02889
PEC Phone (401) 738-1150/ Fax (401) 732-0034

Office use only:

Check #___________
Cleared on:______________

Project Eye Care Program is designed for people who:

1. Are considered to be low income ACCORDING TO RHODE ISLAND HUD INCOME GUIDELINES.
2. Are documented U.S. citizens.
3. Do not have eye care insurance through an HMO, Medicaid, Medicare or the VA, or insurance does not cover the cost of prescription glasses ***and*** you are considered low income.
4. Have not seen an eye care professional in three or more years, or/ have a documented medical condition that has an immediate effect on your vision ***and*** are considered low income.
5. Have not received vision services from any sliding scale or free services within the past three years.

Application Process:

1. Complete **both sides of this application** and return to above address with $30.00 application fee. (Please do not consider this application approved until contacted by Saving Sight)
2. Application **MUST** include all of following to be processed. **COPY OF IDENTIFICATION, COPY OF PROOF OF INCOME.**

Please be aware: This program does NOT provide: progressive, tinted, transitional, contacts or any other type of cosmetic related services.

Reading glasses can be purchased at local pharmacies, dollar stores and Outlet stores for a small fee, therefore **this program does not provide reading glasses.**

CLIENT INFORMATION	**Date of Application:**
Client S.S.# (*Required*) **D.O.B: ___/____/_____** **Age ( )** ☐ **Male** ☐ **Female**	
First Name: **Middle Initial:** **Last Name:**	
Home Address:	**City:** **Zip Code:**
Mailing Address(*if different*)	**Telephone No.**
Referred by: (Facility): ____	

DOCUMENTATION: COPIES OF INCOME AND IDENTIFICATION MUST BE PROVIDED AT TIME OF APPLICATION.
PLEASE COMPLETE REVERSE SIDE OF THIS APPLICATION FORM.
APPLICATION WILL NOT BE PROCESSED IF REVERSE SIDE IS NOT COMPLETED AND SIGNED.

1. Do you currently have Health Insurance? ☐ No ☐ **YES**	**Type of Insurance:** ☐ **Medicaid** ☐ **Medicare** ☐ **SSI** ☐ **Other (*Name of Insurance)*______________________**
2. Date you last received eye glasses and/or exam from any source:	______/_________/________ ☐ **Glasses** ☐ **Exam** ☐ **Both** **Source:**____

Are you applying for eye care due to an ongoing medical condition? ☐ YES ☐ NO
What is the Medical Condition? ☐ Glaucoma ☐ HIV ☐ Diabetes ☐ OTHER
PLEASE NOTE: If you are applying due to an ongoing medical condition that effects your vision written Documentation required by primary care physician. Documentation must be submitted along with application.

☐ Please check if you are applying for any of these services.	☐ **Visual Aid equipment** ☐ **Eye Surgery** ☐ **Other:_____________________** **Supporting Documentation from Eye Care Professional must be submitted with application:**

WHAT SERVICES YOU ARE REQUESTING?

☐ Eye Exam ☐ Glasses *(have prescription)****** ☐ Both Exam and Glasses***

Client Signature:

(Rev 12/2009)

INCOME CERTIFICATION FORM

1. **Family Income Limits required by the U.S. Dept. of Housing & Urban Development – You must circle the family income that applies to you-** *please check one***.**
2. **This page must be signed and dated.**

***INCOME* LEVEL**	**1 PERSON**	**2 PERSON**	**3 PERSON**	**4 PERSON**	**5 PERSON**	**6 PERSON**	**7 PERSON**	**8 PERSON**
	0 - 15,200	**0- 17,350**	**0 - 19,500**	**0- 21,650**	**0- 23,400**	**0- 25,150**	**0- 26,850**	**0- 28,600**
	15,201- 25,600	**17,351- 29,250**	**19,501- 32,450**	**21,651- 36,050**	**23,401- 38,950**	**25,151- 41,850**	**26,851- 44,750**	**28,601- 47,600**
	25,601- 40,400	**29,251- 46,200**	**32,451- 51,950**	**36,051- 57,700**	**38,951- 62,350**	**41,851- 66,950**	**44,751- 71,550**	**47,601- 76,200**
	40,401- above	**46,201- above**	**51,951- above**	**57,701 above**	**62,351 above**	**66,951- above**	**71,551- above**	**76,201- above**

Family means all persons living in the same household who are related by birth, marriage or adoption.

Ethnicity: (*select one only)* _____ Hispanic or Latino ____ Not Hispanic or Latino

Race: (select *one or more)*

____ White
____ Black /African American

____ Asian
____ American Indian/Alaskan Native
____ Native Hawaiian/Other Pacific Islander
____ American Indian/Alaskan Native & White

____ Asian & White
____ Black/African American & White

____ Am. Indian/Alaskan Native & Black/African Am.
____ Other Multi-Racial
____ Black/Hispanic
____ White/Hispanic

Other: *(select all that apply)*

_____ Seniors (62 years or older)
_____ Handicapped or Disabled
_____ Female Head of Household
_____ Minors (up to age 18)

I certify, under the penalties of law, this income information is correct and I understand that the information I have provided on my family income is subject to verification by authorized representatives of the U.S. Department of Housing and Urban Development. **This information will be kept confidential and used for HUD monitoring purposes only.**

_______________________________________ _________________________________
Applicants' Signature Printed Name

If client is below 18 years of age, parent or legal guardian must verify income and sign form.

Signature of Parent/Legal Guardian ___________________________________ Date: __________