The Pokagon Fund
Vision Program

THE POKAGON FUND

Case No. _____
(For internal use only)
Application
for Vision Services

____ Youth Application, child age 9 months through 12th grade
____ Senior Application, adult 50 years of age or older

1. Patient Information:
Name _____ Date of Birth __ / ___ / __ Age ____Grade ____ Male___ Female ___
Home Address _____ City _____ State _____ Zip _____
Mailing Address _____ City_____ State_____ Zip _____
Phone _____ Email _____

2. Parent/Guardian Information (If applicable)
Full Name _____ Relationship to patient _____
Address (if different than patient) _____ City_____ State_____ Zip _____
Phone_____ Email _____
Child resides with (Check all that apply) _____Father_____Mother____Stepparent_____Grandparent_____Other____

3. Insurance Information:
Do you have Vision Insurance: _____ Yes _____No Do you have Medical Insurance? ____Yes ____No
Who is your insurance through? ____ VSP _____BCBS _____Medicare _____ Medicaid _____MiChild _____ other
Secondary Insurer name _____

4. Previous Eye Care Information:
Has the patient ever had an eye exam? ____ Yes ____No If yes, date_____ where: _____
Does the patient currently wear glasses? ____Yes ____No If yes, since when _____
When did you last apply for The Pokagon Vision Fund? (date) _____
If you were approved, when did you last use the program at a Vision Service Provider? (date) _____

5. Income Eligibility: (To be completed by Seniors Only)
How many people are currently in your household? ____
Please state the total amount of income for all of the people in your household:
a.Total household adjusted gross income …….. $_____
b.Total household nontaxable social security benefits…… $_____
c.Total household income (add lines a. and b.)…….. $_____

6. I understand that the above information is being provided to qualify for The Pokagon Fund Vision Program and that completion of this form alone does not constitute eligibility. I further certify that the above statements are true and that no information called for herein has been omitted. I understand that if I give false information, I or my child may lose benefits. I understand that all fields must be answered. I understand that all information is subject to verification and I will do my best to provide the supplemental documents if so requested or be subject to denial.

7. Applicant Signature: _____ Date: _____

8. IMPORTANT: Please submit this application **along with documentation such as a copy of your driver's license, tax bill, or utility bill, lease or other supporting documents verifying your residency in one of the following zip codes: 49115, 49116, 49117, 49125, 49128, 49129 (please do not send originals as they will not be returned)**. Please submit one application and one proof of residency PER applicant, joint applications are NOT accepted.
In order to be considered for a vision examination or glasses, you must submit your application to: The Pokagon Fund Vision Program, 821 E. Buffalo Street, New Buffalo, MI 49117. Applicants will be notified in writing of their eligibility within 30 days of receipt of the application. If you have any questions about this application or the Vision Program, contact The Pokagon Fund at (269) 405-FUND (3863) or visit The Pokagon Fund website at www.pokagonfund.org/visionprogram.