

Case No. _____

The Pokagon Fund
Vision Program



(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 _____
Township Residence _____
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 annual income for all of the people in your household:
a. Total annual household adjusted gross income \$ _____
b. Total annual household nontaxable social security benefits..... \$ _____
c. Total annual 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 townships: New Buffalo, Three Oaks, or Chikaming Township and zip codes: 49115, 49116, 49117, 49125, 49128, or 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) 469-9322 or visit The Pokagon Fund website at www.pokagonfund.org/visionprogram.