

OFVA Vision Assistance Form - English

Please fill out the form below. Required fields are marked with asterisks (*). Your completed form will be reviewed to determine eligibility. If you are qualified, you will be contacted. Verification may be requested. All information will be used for healthcare purposes only.

Oregon Foundation for Vision Awareness, 4404 SE King Road, Milwaukie, OR 97222

* Indicates required question

1. Email *

Patient's Information

2. First Name *

3. Last Name *

4. Date of birth *

Example: January 7, 2019

5. Date of last eye exam *

Example: January 7, 2019

6. Address *

7. City / State / Zip *

8. Contact phone number *

9. What is your preferred method of communication?

Financial Information

Once your application is submitted and reviewed, we may ask for additional information or proof of income.

10. Does the patient have private or government insurance. Medicaid or Medicare [OHP] that covers exams? *

Mark only one oval.

Yes

No

Other:

11. Is anyone in the household currently working at least part time ? *

Mark only one oval.

Yes

No

Other:

12. What is the total number of people in your household living with you, including yourself? *

13. What was your household's approximate gross income [before taxes and deductions] including income from other sources such as alimony and child support? Please indicate amount from last month. *

School Information

Please fill out this portion if patient is an individual under 18 years of age.

14. School name

15. School address

16. School contact person [school teacher, nurse or counselor]

17. School contact person phone number

3rd Party Applications

If you are a school nurse or case worker, please fill out this section

18. Name

19. Contact email

20. Contact phone number

Other Information

21. Please list any circumstances that may limit your access to vision care [example; transportation, financial hardship, seasonal or temporary income]

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