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

* Required

Patient's Information

1. First Name *

2. Last Name *

3. Date of birth *

Example: January 7, 2019

4. Date of last eye exam *

Example: January 7, 2019

5. Address *

6. City / State / Zip *

7. Contact phone number *

Financial Information

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

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

Mark only one oval.

- Yes
- No
- Other: _____

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

Mark only one oval.

- Yes
- No
- Other: _____

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

_____

11. 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.

12. School name

_____

13. School address

_____

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

_____

15. School contact person phone number

_____

Other Information

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

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