FINANCIAL ASSISTANCE FORM

Applicant/Patient's Name _____ Birthdate _____

When applying for Financial Assistance for a **Low Vision Evaluation** the following must be completed by a Physician or accompanied by current documentation from a Physician.

Onset of vision loss (date) _____

Diagnosis _____

Optics/Aids Used _____

Other Medical Concerns _____

_____

_____

Current Optometrist/Ophthalmologist _____

_____