

CALIFORNIA VISION PROJECT (CVP) APPLICATION FORM

The California Vision Project provides free eye exams to eligible low-income working families.
Services are donated by volunteer optometrists throughout California.

Eligibility requirements: All eligibility requirements must be met in order to qualify (PLEASE READ)

- At least one adult in the household must be employed (full-time or part-time);
- The person(s) seeking an eye exam must have no public or private insurance that covers eye exams;
- Applicants must not have had an eye exam in the last 2 years; and
- Applicants are low-income and are unable to pay for eye care.
- \$10.00 non-refundable administrative fee (per person) must accompany the application. Check or money orders can be made payable to "The California Vision Foundation"

Please answer all questions below. Verification may be requested.

1. Is anyone in your household currently employed (full-time or part-time)? Yes No
2. What is the total number of people in your household living with you, including yourself? _____
3. What was your household's approximate gross annual income before taxes and deductions? _____
4. How far are you able to travel for your appointment? _____ miles
Please list any particular cities that you would be able to travel to for your appointment:

List all family members who are applying for a free eye exam:

Name	Date of Birth	Has this person had an eye exam in the last two years?	Does this person have any private or government insurance that covers eye exams?
1.	/ /	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
2.	/ /	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
3.	/ /	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
4.	/ /	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No

Home address: (Please print)

Address _____

_____ Apt. # _____

City _____

State _____ Zip _____

Daytime telephone number () _____ - _____

Employer address: (Please print)

Address _____

City _____

State _____ Zip _____

Work telephone number () _____ - _____

Your completed form will be reviewed to determine your eligibility. Eligible patients will be notified by mail and will receive a complete eye exam without cost if a volunteer is available in your area.

Mail this completed application with the \$10.00 Administrative Fee(s) to:
California Vision Foundation

2415 K Street, Sacramento, CA 95816

If you have any questions please contact Megan Gowin or Michelle Harvey at (800) 877-5738.