

# Application for LensCrafters Gift of Sight Program

**NOTE:** *The Arc Upper Valley is a referring agency for the Lenscrafters Gift of Sight Program. Referrals can only be made for individuals residing in our service area, which is the upper eastern portion of North Dakota.*



Send completed application to:

**Gift of Sight Program**  
c/o The Arc, Upper Valley  
2500 DeMers Ave  
Grand Forks ND 58201  
(701) 772-6191

## APPLICANT

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NAME: \_\_\_\_\_ PHONE: \_\_\_\_\_

ADDRESS: \_\_\_\_\_ CITY: \_\_\_\_\_

STATE: \_\_\_\_\_ ZIP CODE: \_\_\_\_\_ COUNTY: \_\_\_\_\_

DATE OF BIRTH \_\_\_\_\_

MARITAL STATUS: (check one)  SINGLE  MARRIED  DIVORCED  WIDOWED

NUMBER OF PEOPLE IN APPLICANT'S HOUSEHOLD: \_\_\_\_\_

NAME OF ADDITIONAL PERSON(S)	AGE	RELATIONSHIP TO APPLICANT
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

## FINANCIAL INFORMATION

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ARE YOU EMPLOYED?:  YES  NO MONTHLY WAGE: \$ \_\_\_\_\_

IS YOUR SPOUSE EMPLOYED?:  YES  NO SPOUSE'S MONTHLY WAGE: \$ \_\_\_\_\_

OTHER MONTHLY INCOME \$ \_\_\_\_\_ SOURCE \_\_\_\_\_

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DO YOU HAVE MEDICAL INSURANCE (OTHER THAN MEDICARE OR MEDICAID)?:  YES

**REFERRING AGENCY (IF ANY)**

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AGENCY NAME \_\_\_\_\_ PHONE \_\_\_\_\_

CASEWORKER \_\_\_\_\_ ADDRESS \_\_\_\_\_

**PROGRAM STIPULATIONS**

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1. RECIPIENT IS RESPONSIBLE FOR THE EYE EXAM FEE OF \$40.
2. RECIPIENT IS RESPONSIBLE FOR TRAVEL TO AND FROM APPOINTMENTS, WHICH WILL TAKE PLACE AT LENSCRAFTERS IN FARGO, ND.
3. RECIPIENT WILL RECIEVE ONE PAIR OF FREE EYEGLASSES. (LIMITED TO THE STYLES AND COLORS AVAILABLE). FREE EYEGLASSES CANNOT BE TINTED OR MADE INTO SUNGLASSES.
4. IF EYEGLASSES ARE BROKEN OR LENSES SCRATCHED, THEY CANNOT BE REPLACED WITHOUT ANOTHER REFERRAL.
5. THIS PROGRAM IS NOT DESIGNED FOR PERSONS WHO HAVE HAD OR ARE HAVING LASIK SURGERY.
6. LENS CRAFTERS HAS THE RIGHT TO DECLINE ANY RECIPIENT IF THEY HAVE MIS-STATE INFORMATION ON THIS APPLICATION OR ARE NOT ABIDING BY PROGRAM RULES.

**To the best of my knowledge, the information provided on this form is a full and accurate disclosure of my current financial status. I understand and agree to the above stated stipulations of LensCrafters Gift of Sight Program.**

\_\_\_\_\_  
Signature of applicant

Date \_\_\_\_\_

\_\_\_\_\_  
Signature of parent or guardian (if applicable)

Date \_\_\_\_\_

\_\_\_\_\_  
Signature of caseworker (if applicable)

Date \_\_\_\_\_

**OFFICE USE ONLY - DO NOT WRITE BELOW THIS LINE**

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