



217 Clarkson Rd. • Ellisville, MO 63011 • tel. 636.227.2600 • fax 636.200.4020

APPLICATION FOR ASSISTANCE

I. Referring Organization: _____

II. Patient Information - Circle one: Child / Adult DOB: _____

Name: _____

Street Address: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Work Phone: _____

III. Parent / Guardian / Person Taking Patient to Appointment

Name: _____

Street Address: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Work Phone: _____

IV. Please provide your insurance information: _____

V. Request (Please Select those that that apply)

Eye exam Glasses

Please provide detail to help us understand your need and the conditions regarding your request. The Clarkson Eyecare Foundation's mission is to improve vision for those that are unable to afford these services.

(We reserve the right to deny an application based on the criteria provided by the applicant.)

Signature: _____ Date: _____

Please mail to: Clarkson Eyecare Foundation, 217 Clarkson Rd., Ellisville, MO 63011

www.theclarksoneyecarefoundation.org

Mission Statement: The Clarkson Eyecare Foundation is dedicated to enhancing quality of life by providing vision improvement and access to a brighter future.



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APPLICATION GUIDELINES

I. Total Family Income

_____ / month

_____ / year

II. Family Size _____

FAMILY SIZE	ANNUAL INCOME	MONTHLY INCOME
1	\$19,140	\$1,595
2	\$25,660	\$2,138
3	\$32,180	\$2,681
4	\$38,700	\$3,225
5	\$45,220	\$3,768
6	\$51,740	\$4,312
7	\$58,260	\$4,855
8	\$64,780	\$5,398

Proof of your total income can be any ONE of the following:

- first page of most recent Income Tax Return and the accompanying W-2 form(s) and/or
- two months of pay stubs, or YTD pay stub and/or
- award letter(s) from Social Security office or SSA 1099 Social Security Benefit statement and/or
- food stamp card and/or
- letter from Division of Family Services stating income

INFORMATION ON THIS FORM WILL BE KEPT CONFIDENTIAL

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