POMONA UNIFIED SCHOOL DISTRICT
HEALTH SERVICES & PROGRAMS

VISION ASSISTANCE APPLICATION - Marshall Lions Clinic ONLY

(One application per student)

DATE: _____ **STUDENT'S NAME:** _____

DOB: _____ **STUDENT SOCIAL SECURITY NUMBER:** XXX--XX--_____

SCHOOL SITE: _____ **GRADE:** _____

PARENT'S NAME: _____ **ETHNICITY:** _____

COMPLETE ADDRESS: _____

HOME PHONE NUMBER: ( ) _____ **CONTACT NUMBER: ( )** _____

INCOME REQUIREMENTS: CHECK STUB MUST BE ATTACHED IN ORDER TO PROCESS THE VISION APPLICATION. IF SELF-EMPLOYED, PLEASE PROVIDE STATEMENT INDICATING YOUR WEEKLY OR MONTHLY INCOME.

Please provide the number of family members: _____

I am providing this statement to verify my income, as I have no other income documentation available to me. I receive $_____(gross amount) and the frequency of pay is:

☐ Every week ☐ Twice a month

☐ Every two weeks ☐ Once a month

I last received this amount on the following date: _____

I certify that the information presented in this letter is correct to the best of my knowledge and belief.

Parent's Signature: _____

INSURANCE INFORMATION

Does your child have insurance coverage at this time?	Yes or No
(Examples of plans: Kaiser, Blue Cross/Blue Shield, Health Net)	
Does your plan include Optometry?	Yes or No
Is your child covered under Medi-Cal?	Yes or No
Have you currently applied for Medi-Cal?	Yes or No
Was your child born in the United States?	Yes or No

If your child has Medi-Cal, please write the ID # here:_____

****Please attach a copy of your child's Medi-Cal card**

Currently, all appointments take place on Wednesdays at the Marshall Lions Vision Clinic.

INTERNAL INFORMATION (for office use only)

Referral Criteria:_____

Nurse Signature: _____

Approved:_____ Date:_____