Please fill out the form below. Required fields are marked with asterisks (*). Your completed form will be reviewed to determine your eligibility. If you are qualified, you will be contacted. Verification may be requested. All information will be used for healthcare purposes only.

Please fill out this form and fax it to 503-659-4189 or mail to:
OFVA
4404 SE King Road
Milwaukie, OR 97222

Child's Information

First Name: * _____

Last Name: * _____

Date of Birth: * _____

Social Security Number: * _____
(Required. If child does not have a SS#, please include the SS# of a parent, guardian or family member. Application cannot be processed without a SS#)

Date of last eye exam: _____

Parent Information

Parent Name: * _____

Address: * _____

City: * _____

State: * _____

Zip: * _____

Home Phone: * _____

Email Address: * _____

Financial Information

Does this Child have private or government insurance, Medicaid or Medicare (OHP) that covers exams? *
Yes No

Is anyone in your household currently working at least part-time? *
Yes No

What is the total number of people in your household living with you, including yourself? * _____

What was your household's approximate gross income (before taxes and deductions) including income from other sources such as alimony and child support?

Please enter whole dollar amount only.
Last month: $ _____

OR Last year: $ _____

How would you prefer to be contacted?

Phone Email

School Information

School Name: _____

School Address Information: _____

_____

Contact Name: _____

Title: _____

School Phone: _____

County: _____

Please list any other circumstances that limit your access to vision care (i.e. transportation)

_____

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