

# APPLICATION FOR THE KENTUCKY VISION PROJECT



Please return this application to  
 Kentucky Vision Project, P.O. Box 1422, Frankfort, KY 40602

**IF THIS FORM IS INCOMPLETE, IT WILL NOT BE PROCESSED.**

1. Today's date \_\_\_\_\_ 2. SS# \_\_\_\_\_ 3. County \_\_\_\_\_

4. Name \_\_\_\_\_

5. Street Address (Mailing Address) \_\_\_\_\_

6. City \_\_\_\_\_ 7. State \_\_\_\_\_ 8. Zip \_\_\_\_\_

9. Phone # ( ) \_\_\_\_\_ - \_\_\_\_\_ 10. Email \_\_\_\_\_ 11. Date of Birth \_\_\_\_\_

12. If there is no participating doctor in your county I will travel to: (List 2 Counties)

1. \_\_\_\_\_ 2. \_\_\_\_\_

When was your last eye examination? \_\_\_\_\_ Name of Doctor \_\_\_\_\_

13. Family Member Information: You must include everyone living in your household including yourself.

Family Member Name	Relationship	Age	Covered by Medicare?	Medicaid?	Check those who need an appointment
	<b>Applicant</b>				<b>X</b>

## COMPLETE REVERSE SIDE

<p><b>Office Use Only</b> "....."Dcvej 'F cvgaaaaaaaaa</p> <p>"OD _____ aaaaaaaaaa 'QF 'Ekw{ 'aaaaaaaaaaaaaaaaaaaaa</p> <p>.....</p> <p>Other _____ aa</p> <p>.....</p> <p>.....</p>	<p>OD ID _____</p> <p>OD ORG _____</p> <p>OD Total _____</p>
--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------	--------------------------------------------------------------

