LIONS ASSOCIATION FOR SIGHT & HEARING OF MARYLAND, INC.
EYEGLASS ASSISTANCE REQUEST

1. Do you have insurance with vision benefits? **If YES—NOT ELIGIBLE If NO, go to #2**
2. Does Medicaid cover your eye exam benefits? **If YES—NOT ELIGIBLE**

   IF NO, and you haven't had an eye exam in 12 months—**go to #3**
3. How many individuals in your household? _____
4. Household gross monthly income (before taxes or insurance): include the income of everyone

   $ _____ Is the annual total more than the amount in the table below for the number of people in your household?

   IF Yes, it is above the level — **NOT ELIGBLE**

   IF No, below the income level — **go to #5**

2025 Poverty Guidelines for the 48 Contiguous States and the District of Columbia

Persons in family /household	Poverty Guideline
1	$31,300
2	$43,300
3	$53,300
4	$64,300

For each additional person in the household—add $6,300

5. Applicant Name: _____Date of Birth:_____

   Street Address: _____ Apt #:_____

   City: _____State: **MD** ZIP Code:_____

   Phone Number:_____ Alternate Contact Phone #: _____

I certify that the above information is true and correct to the best of my knowledge.

Signature: _____ Date:_____

Printed Name: _____

REFERRING PERSON & ORGANIZATION

Name: _____ Position: _____

Organization: _____

Phone #:_____Email: _____

Return the completed form to:

Lions Association for Sight & Hearing of Maryland
Attn: Sight Chair
PO BOX 821
Bel Air MD 21014-0821