ARIZONA ODD FELLOW-REBEKAH VISUAL RESEARCH FOUNDATION INC.
ASSISTANCE FOR EYE CARE

APPLICANT _____
(Last) (First) (MI

Present Address _____

City _____ ARIZONA ZIP_____

Telephone HOME _____ CELL _____ OFFICE _____

Are you employed _____ Retired _____ Disabled _____

Membership is not a requirement, however are you a member of an Odd Fellow or Rebekah Lodge in Arizona? _____Lodge Name: _____
Does your insurance have vision coverage for applicant? _____
Does the applicant/patient wear glasses or contacts now? _____

Date of the last eye examination _____

Approximate cost of treatment? _____ Amount requested _____

If you are receiving Federal or State assistance funds your benefit may be reduced by the amount received from this program. MUST BE A FULL TIME RESIDENT OF ARIZONA.
I certify that all statements in this application are true and complete and request financial assistance from the **ARIZONA ODD FELLOW-REBEKAH VISUAL RESEARCH FOUNDATION, INC.**
I also understand that the **MAXIMUM** amount of assistance is up to **$250.00**. OR ACTUAL COST OF EXAMINATION AND GLASSES WHICH EVER IS LESS. **LIMIT ONE (1) PAIR OF GLASSES PER YEAR.**

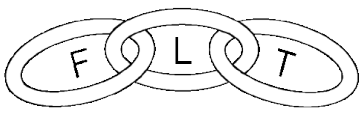
DATE: _____ _____
(Signature of Applicant or Guardian)

REFERRED BY: _____
(Signature of a Foundation Trustee or Lodge Member)

Mail or Give to your Referring Trustee of the Arizona Odd Fellow-Rebekah Visual Research Foundation, Inc. <u>WITH ATTACHED COPY OF INVOICE FROM PRESCRIBER</u>

NAME OF TRUSTEE: _____
Address of Trustee: _____
City, State, ZIP: _____

TRUSTEE, MAIL TO:
ARIZONA ODD FELLOW-REBEKAH VISUAL RESEARCH
Attn: Henry Imel
P.O. Box 419 Fair Acres, NM 88033



Revised: July 2023