THE COMMUNITY FOUNDATION
Shelby County

John Douglas Long Blind Fund
Grant Application for Vision Care

Patient's Name:_______________________________________Phone:____________________
Address:____________________________________City, Zip Code:______________________
Age:________ Marital Status: *(Circle one)* Single Married Widowed Divorced Separated

Patient's Vision Ailment:____
Treatment Recommended:____
Total Cost of Treatment and/or Equipment: $____________________
Amount requesting from the John Douglas Long Fund: $____________________
Referring person:____________________________Organization:________________________

Patient's Place of Employment:____
Spouse's Place of Employment: ____
If patient is younger than age 18 and/or a student:
Mother/Stepmother's Place of Employment: ______________________________________
Father/Stepfather's Place of Employment: _______________________________________

Number of adults (age 18 and older) living in the home:_____________
Number of children (under age 18) living in the home:______________

What is the total monthly gross income(before taxes) of adults living in the home:___________
What is the total monthly "take home" pay (after taxes) of adults living in the home:_________
Are there other sources of income not listed in the "Employment" section above? yes___ no___
If yes, please list other sources of income:______________________________________
____
Is the patient covered by insurance which pays for treatment of this problem? yes___ no___
If yes, please explain why you are requesting financial assistance:_______________________
____
Is the patient covered by Medicaid, CareSource or Medicare? yes____ no_____
If yes, please explain why you are requesting financial assistance: ______________________
____
Please give a history of past vision problems:____
____

If there is more information that may affect our decision, please attach a sheet.

Has the patient requested help with vision expenses within the last 2 years from:
Sidney-Shelby County Health Dept. yes no
Compassionate Care yes no

I certify that the above information is true to the best of my knowledge and I hereby release The Community Foundation of Shelby County from any and all liability for any vision or medical treatment which I may receive because of a grant.

Patient Signature:____ Date:__________________
(or Power of Attorney)

Parent/Guardian Signature:______________________________(required if patient is under 18)

Please mail this application to The Community Foundation
100 S Main Ave, Suite 202, Sidney OH 45365-2771

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