Cost of glasses – Basic prescription: $30.00; Bifocals: $45.00
Higher prescription may cost more.
No personal checks accepted

LIONS OPTOMETRIC VISION CLINIC (LOVC) APPLICATION

1805 Upas Street, San Diego, CA 92103 – Phone: (619) 298-5273 – Fax: (619) 298-5297
Hours of business: Monday – Friday 9:00a.m. to 1:00p.m.

*****The information on this application is Confidential*****

The clinic is dedicated to helping those in need of eyeglasses. Our primary goal is the preservation of eyesight. The following information will assist us in determining eligibility for an appointment. Patients are treated **only** in our clinic or the clinics of the participating volunteer optometrists. **We do not pay** for exams performed in private facilities. **Please print legibly and accurately.**

APPLICANT INFORMATION: ***(Items 1-12 must be completed by all applicants. In cases applicant is under 18 yrs. Old, please provide parent/guardian information for #6-12)***

1. Name: ______________________ Phone #: ______________ Cell #: ______________
2. Address: ______________________ City: ______________ Zip: ______
3. Birth date: ______________ Gender: ________ Marital status: ______________
4. Have you obtained glasses from our clinic before? ____ If yes, when? ______________
5. If under 18 yrs old, name(s) of parent/legal guardians(s): ______________________
6. Occupation: ______________________ Gross monthly income? ______________
7. Spouse: ______________________ Gross monthly income? ______________
8. Length of employment: ______________ Spouse: ______________
9. Are you a San Diego County resident? ____________ How long? ______________
10. Number of dependents: ______ Ages: ______________________
11. Please provide any other income amount and source: $__________ Source: ______________
12. Are you a dependant of military personnel? (Explain): ______________________

Signature of Applicant/Parent/Guardian: ______________________ Today's date: __________

REFERRING AGENCY INFORMATION: The referring agency is responsible for determining if the person referred meets financial eligibility (family income at or below 200% of the Federal Poverty Level) and has no vision insurance. ***Failure to comply may cause denial of service.***

Name & address of referring agency or school: ______________________

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Name, title & phone number of authorized representative: ______________________

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Explain why you believe this person qualifies for services offered by the clinic: ______________________

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Signature of referring representative: ______________________ Today's date: __________