**APPLICATION FOR FINANCIAL ASSISTANCE**
**FROM THE ANTONE L. SMONGESKI HEALTH FUND**

Note: Application must be made **BEFORE** making an appointment with your eye doctor

Complete this form and return to: THE ANTONE L. SMONGESKI HEALTH FUND
ATTN: LISA KUEHN
POST OFFICE BOX 87
TWO RIVERS WI 54241-0087

| | |
|---|---|
| Father's Full Name: | Employer: |
| Address: | |
| Mother's Full Name: | Employer: |
| Address if different from above: | |
| Phone Number: | |
| Total Number of Children at Home: | Eye Doctor/Clinic: |

| | |
|---|---|
| Child's Full Name: | Date of Birth: |
| School: | Grade: |

Do you have **any** vision insurance? Yes No - - If yes, you are **not** eligible for this assistance.

Do you have Medical Assistance? Yes No - - If yes, you are **not** eligible for this assistance.

I hereby state that I am familiar with the provisions that the child must be between the ages of 5 and 16 years, a resident of the City of Two Rivers, and because of financial need, require assistance.

_____ _____
Signature of Parent/Guardian Date of Application

The following to be completed by the Antone L. Smongeski Health Fund Committee:

By:_____