EPISCOPAL CHARITIES OF ALBANY
GRANT APPLICATION FORM – EYE CARE

Revised July 6, 2021

EPISCOPAL CHARITIES OF ALBANY offers direct assistance in the form of grants to indigent persons regardless of faith, who are in need of eye care, or who otherwise suffer from eye disorders, and are unable to afford such eye care of necessary related services. Grants are limited to eye examinations, purchase of eyeglasses and special equipment or medication needed by an individual by reason of his or her suffering from eye disease and surgical procedures to restore or maintain normal vision. Grant awards are limited to those residing within 19 counties of the Episcopal Diocese of Albany.

Name: ____
Home address: ____
Phone: ( ) ________________ **Email:** ____

Application for financial aid: ***(Check all items that apply)***

___Eye examination	___Medication	___Eye glasses
___Surgical procedure	___Special eye equipment	___Other (Explain below)

Brief description of eye disorder: ***(Attach copy of Physician's diagnosis)*** _________________________
____
____
____

Estimated cost of treatment:	$__________
Amount ***(if any)*** **covered by insurance:**	$__________
Amount ***(if any)*** **covered by other sources:**	$__________
Amount requested :	$__________

To be expended between _______________ **and** _______________

NOTE: WRITTEN ESTIMATE FROM TREATMENT PROVIDER OR PROVIDER'S INVOICE IS REQUIRED WITH APPLICATION

Have you applied for or received other financial aid for your eye disorder? Yes_____ No_____ If yes, provide details on a separate sheet.

Annual family income: $__________ ***(Submission of a recent Federal Tax Form filed with the I.R.S. is recommended with this application.)***

Describe financial need:____
____
____

Other information you feel is pertinent:____
____
____
____

How did you hear about the Episcopal Charities of Albany Eye Care Grant Program? ____________
____

Is applicant a parent or guardian submitting this request on behalf of a minor or another person needing treatment? Yes____ No____ If yes, describe relationship: ______________________________
____
____

I the undersigned, if awarded a grant, agree to use the funds for the above described purpose and to return any unused portion within the grant period.

Signature____________________________________ **Date_________**

Birth date of Applicant (the person designated in need of treatment) **_____/___/______**

Return completed form to:
Episcopal Charities of Albany, Inc., 580 Burton Road, Greenwich, NY 12834 Attn: ECA Administrator

FOR OFFICE USE ONLY

DATE RECEIVED_______________ DATE REVIEWED________________

ACTION TAKEN ____

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DATE APPLICANT NOTIFIED OF ECA DECISION_____________________

METHOD OF NOTIFICATION:

EMAIL ____ REGULAR MAIL____ PHONE ____ OTHER (Explain)_______