

VISUAL ASSISTANCE APPLICATION

INDEPENDENT ORDER
of
ODD FELLOWS



GRAND LODGE

REBEKAH ASSEMBLY
of
MONTANA



I state that the information contained in
this application is correct to the best of my
knowledge.

Name of Applicant _____

Address _____

City _____ Zip _____

Telephone _____

Signed _____

Date _____

General Criteria to Receive Assistance With Eye Care

The applicant does NOT have to be a member of Odd Fellows or Rebekahs.

The need for assistance is the most pertinent criteria.

This application along with a written personal letter from the applicant or representative of applicant, stating the reason for the request must be presented to an Odd Fellow or Rebekah Lodge within the jurisdiction of Montana for review and approval. If the sponsoring Lodge feels the need is legitimate, it is signed under the seal of that Lodge by the Noble Grand and Secretary, and then forwarded to the Visual Assistance Committee for final review.

The Chairperson and one or two other committee members must approve the amount to be provided. The amount requested is not necessarily the amount that is approved.

If approved, the funds will be sent to the sponsoring Lodge, which will then issue a check directly to the eye care provider.

In no case will the funds be paid directly to the applicant. If the bill has already been paid to the eye care provider by the applicant or representative, no reimbursement will be issued and this application will be deemed null and void.

After filling out the following information,
take this application to your eye care
provider, who may also be able to work
with you to assist you with your needs.

Total Annual Income for Applicant's
Immediate Family:

Number of Individuals being supported by
this income:

**Following to be filled out by Eye Care
Provider**

Name: _____

Address: _____

Phone: _____

Total Estimate for Eye Care: \$ _____

What is included in this estimate? _____

Does patient have Insurance or Medicare?
Yes No (If yes, circle which)

Will you negotiate a payment plan for
remainder of bill with patient? Yes No

Signed: _____

Eye Care Provider

To be filled out by Sponsoring Lodge

LODGE

Name _____

Location _____

Approved? Yes ___ No ___

Noble Grand _____

(Lodge Seal)

Secretary _____

Visual Assistance Committee Approval

Amount Approved \$ _____
