Healthy Eyes/One Sight

Glasses Voucher Application

To qualify for our voucher program, there are certain eligibility criteria that must be met. The following questions will determine if you qualify.
THERE ARE 2 PAGES TO COMPLETE

1. Name: ______________________________ Date of Birth: ________________
   Month/Day/Year

   Address: ____

   City: ___________________________ State: _______ Zip Code: _____________

   Best Contact Telephone Number: (______) ____________________________

2. Have you had a vision **screening (not an exam)**? (circle one) Yes No

   If **YES**, did you fail the screening? Yes No

3. Are you enrolled in Medicaid, Medicare or other vision insurance? Yes No

   If **YES**, have you already used the vision benefits available? Yes No

4. Have you used a voucher from Prevent Blindness in the last 12 months? Yes No

5. What is the **YEARLY** family income? $ ________________________

6. How many members belong to the family? (include parents and children) Circle number below.

   1 2 3 4 5 6 7 8 Other _______

7. A current prescription is necessary to receive this voucher. What is the date of that prescription? ______________________________

8. How did you hear about Prevent Blindness Mid-Atlantic/voucher program?

   ____

SEE REVERSE SIDE FOR MORE QUESTIONS----A SIGNATURE IS <u>REQUIRED</u> IN ORDER TO QUALIFY FOR ASSISTANCE.

*****If you are a client applying for yourself, skip this section and sign/date below.**

AGENCY INFORMATION:

If you are a referring agency (Health Dept., Lions Club, School Nurse, Social Worker, etc.) helping a client complete this application, you must complete this information (PLEASE PRINT):

Referring Agency: ____

Name of Contact: ______________________________E-mail Address: _________________________

Agency Address: ____

Agency/Contact Phone #: (______) ______________ext._____ Agency Fax: (______)________________

**Is voucher to be sent to the agency or directly to the client? (Circle One) AGENCY CLIENT

I attest that the information on this application is true to the best of my knowledge:

____

Client Signature Date

____

Agency Signature (If Applicable) Date

Please send eligible applications to:

Prevent Blindness Mid-Atlantic
ATTN: Alison Markow
11618 Busy Street
Richmond, VA 23236
OR
Fax to: (804) 423-5409
E-mail: Alison@TheEyeSite.org

FOR OFFICE USE ONLY

DATE APPLICATION RECEIVED: ___________________________ VIA: __________________________

QUALIFIED: YES _______ NO _______ DATE VOUCHER SENT: ___________________________

IF **NOT** QUALIFIED NOTIFICATION COMPLETE:
DATE: __________________________CLIENT/AGENCY NOTIFIED: ____

REASON FOR DISQUALIFICATION:
____

STAFF INITIALS: __________________

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