**Adult Vision Care Voucher Application**

**OFFICE USE ONLY 6/20**

Date: \_\_\_\_\_\_\_\_ Staff: \_\_\_\_

□ Approved □ Denied

□ HE □ ME □ MEMO

**Please Return to:** Prevent Blindness Wisconsin ● 731 N. Jackson Street ●

Suite 405 ● Milwaukee, WI 53202

Fax: (414) 765-0377 ● Phone: (414) 765-0505 ● Breanna@pbwi.org

**Applicant Information**

**I am applying for:** □ Glasses Only □ Eye Exam and Glasses

**Name:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Date of Birth:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Address:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**City:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Zip:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **County:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Phone:** (\_\_\_\_\_) \_\_\_\_\_-\_\_\_\_\_\_\_ **Alternate Phone:** (\_\_\_\_\_) \_\_\_\_\_-\_\_\_\_\_\_\_

**Vision Health Information**

**Have you had an eye exam in the last 12 months?** □ Yes □ No

**Date of last eye exam:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Have you used a vision care voucher in the last 12 months?**  □ Yes □ No

If yes,please indicate the type of voucher used:

□ VSP Mobile Eyes □ Healthy Eyes □ Other:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Financial and Insurance Information**

Please provide at least **ONE** proof of income document: pay stub, tax return, Social Security Award Letter etc.

**Annual Household Income:** $ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **# of people in household including yourself:** \_\_\_\_\_\_\_\_

**Do you have Medicaid, VA Health Care or other vision insurance?** □ Yes □ No

***I attest that the above information is true to the best of my knowledge. I understand that if I provide incomplete or incorrect information I may be required to pay for the vision care services I receive and I may be declined service.***

Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**To be completed by agency staff if applying through an agency.**

Name of Agency : \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Name of Contact: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ City: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Zip: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Email: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Send Voucher Information to: □ Applicant’s Home □ Agency

Send Voucher approval letter in: □ English □ Spanish