

**OFFICE USE ONLY 6/20**

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

□ Approved □ Denied

□ HE □ S4S □ MEMO

**Children’s Vision Care Voucher Application**

**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**

**My child needs:** □ Glasses Only □ Eye Exam and Glasses

**Child’s Name:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Date of Birth:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Address:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **City:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Zip:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **County:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Phone:** (\_\_\_\_\_\_) \_\_\_\_\_\_\_-\_\_\_\_\_\_\_\_\_\_\_\_\_

**Parent/Guardian Name:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Vision Health Information**

**Has your child had an eye exam in the last 12 months?** □ Yes □ No

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

**Has your child broken or lost their glasses?** □ Yes □ No

**Has your child used a vision care voucher in the last 12 months?** □ Yes □ No

If yes, please indicate the type of voucher used:

□ VSP Sight for Students □ 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.

**Does your child qualify for free or reduced price lunch?** □ Yes □ No

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

**Does your child have BadgerCare Plus (Medicaid) or other vision insurance?** □ Yes □ No

\*If your child has BadgerCare and needs an eye exam call 1-800-362-3002.

***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 my child receives and my child may be declined service.***

**Parent/Guardian Signature:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**To be completed by school/agency staff if applying through a school/agency.**

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

Send Voucher Approval Letter in: □ English □ Spanish □ Hmong