OFFICE USE ONLY 3/22
Date: _____ Staff: ____
☐ Approved ☐ Denied
☐ HE ☐ ME ☐ MEMO

Adult 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

I am applying for: ☐ Glasses Only ☐ Eye Exam and Glasses

Name: _____ **Date of Birth:** _____/_____/_____

Address: _____ **City:** _____

Zip: _____ **County:** _____ **Email:** _____

Phone: (_____) _____-_____ **Alternate Phone:** (_____) _____-_____

Vision Health Information

Have you received a glasses prescription from an eye doctor in the last 12 months? ☐ Yes ☐ No

If yes, date prescription was written: Day ____ Month _____ Year _____

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.

Yearly Household Income: ☐ $0 - $27,180 ☐ $27,181 - $36,620 ☐ $36,621 - $46,060
☐ $46,061 - $55,500 ☐ $55,501 - $64,940 ☐ $64,941 - $74,380 ☐ $74,381 - $83,820 ☐ _____

# of people in household including yourself: ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ _____

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