**Adult Vision Care Voucher**

**OFFICE USE ONLY 1/23**

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

□ Approved □ Denied

□ HE □ EOH □ EOHG

 **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 - $29,160 □ $29,161 - $39,440 □ $39,441 - $49,720 □ $49,721 - $60,000 □ $60,001 - $70,280 □ $70,281 - $80,560 □ $80,561 - $90,840 □ \_\_\_\_\_\_\_

**# 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