**Children’s Vision Care Voucher Application**

**OFFICE USE ONLY 1/23**

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

□ Approved □ Denied

□ HE □ EOH □ EOHG

**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:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Email:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Vision Health Information**

**Has your child received a glasses prescription from an eye doctor in the last 12 months?** □ Yes □ No

 **If yes,** **date prescription was written:** Day \_\_\_\_ Month \_\_\_\_\_ Year \_\_\_\_\_\_

**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**

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

 If no, 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 □ \_\_\_\_\_

**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