



APPLICATION FOR VISION SERVICES

Please Print Clearly. All questions must be answered to ensure eligibility.

Applicant Information

Child's Name: _____

Date of Birth: ____/____/____

Social Security Number*: ____-____-____ (a valid social security number is required)

SS belongs to: Child Parent Please check one.

If applicant does not have a social security number, a parent or guardian social security number may be submitted instead. If neither have a social security number, applicant is **not eligible for program.*

Address: _____

City: _____ State: _____ Zip Code: _____

Parent/Guardian Name: _____

Relation: _____ Telephone: () _____

Annual Income: \$ _____

Size of Family Unit: _____

- | | | |
|---|------------------------------|-----------------------------|
| 1. Is the child enrolled in Medicaid or other vision insurance? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 2. Is child or parent a US citizen with a Social Security Number? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 3. Has the child used the "Sight for Students" Program during the last 12 months? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 4. Is the child 19 years old or younger and enrolled in school? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |

The above information is correct and true, to the best of my knowledge.

_____/_____/_____
 Signature of Parent/Guardian Date

Voucher Information

Voucher to be mailed to: (Check one) Parent/Guardian (Name and Address Above) School/Agency Contact Person (Please provide address below)

Contact Name: _____

Agency/School Name: _____

Address: _____

City: _____ State: _____ Zip: _____



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ELIGIBILITY REQUIREMENTS

- Family Income is no more than 200% of poverty level (see chart).
- Child is not enrolled in Medicaid and does not have *any* vision insurance.
- Child is 18 years old or younger, and is *still* attending high school.
- Child or parent is a U.S. citizen or documented immigrant with a social security number.

200% of Federal Poverty Guidelines (2018)

Size of Family	Annual Income
1	\$24,280
2	\$32,920
3	\$41,560
4	\$50,200
5	\$58,840
6	\$67,480
7	\$76,120
8	\$84,760
For each additional person add:	\$8,640

BENEFITS

Children meeting the program qualifications are entitled to the following services:

- An eye exam from one of the VSP's participating doctors.
- Glasses, should they be prescribed.
- Medically necessary services, upon authorization.

Benefit Coverage includes:

- | | | |
|--------------------|------------------------|-----------------------------|
| - Oversized Lenses | - Solid Tints & Dyes | - Scratch Resistant Coating |
| - Polycarbonate | - Plastic Gradient Dye | - Low Vision |
| - High Index | - Photochromic | - Color Coat |

Please return this application to:

Email: kpeckingham@healthyeyesalliance.org

Fax: 203-772-4691

Mail: Sight for Students
Healthy Eyes Alliance
129 Church Street, Suite 820
New Haven, CT 06510

Questions? 1-800-850-2020 x102