HEALTHY EYES ALLIANCE®
PREVENTING VISION LOSS IN OUR COMMUNITIES

SIGHT FOR STUDENTS®
A VSP Program

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: ______________________

	Question	Yes	No
1.	**Is the child enrolled in Medicaid or other vision insurance?**	☐ Yes	☐ No
2.	**Is child or parent a US citizen with a Social Security Number?**	☐ Yes	☐ No
3.	**Has the child used the "Sight for Students" Program during the last 12 months?**	☐ Yes	☐ No
4.	**Is the child 19 years old or younger and enrolled in school?**	☐ Yes	☐ 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 (2017)	
Size of Family	**Annual Income**
1	**$24,120**
2	**$32,480**
3	**$40,840**
4	**$49,200**
5	**$57,560**
6	**$65,920**
7	**$74,280**
8	**$82,640**
For each additional person add:	**$8,360**

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
- Polycarbonate
- High Index
- Solid Tints & Dyes
- Plastic Gradient Dye
- Photochromic
- Scratch Resistant Coating
- Low Vision
- 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