



# PREVENT BLINDNESS OKLAHOMA

6 N.E. 63<sup>rd</sup> St, Ste 150 OKC, OK 73105 • 405-848-7123 • www.preventblindness.org

## Application for Vision Service Plan Benefits

**INCOMPLETE OR UNQUALIFIED APPLICATIONS WILL NOT BE PROCESSED**

### *Applicant Information*

Child's Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Address: \_\_\_\_\_ Social Security #: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_ Phone: \_\_\_\_\_

Is the applicant currently **receiving** Medicaid benefits?  Yes  No

### *Parent/ Guardian Information*

Name: \_\_\_\_\_ Relation to Applicant: \_\_\_\_\_

Address: \_\_\_\_\_ Social Security #: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_ Home Phone: ( ) \_\_\_\_\_

Does applicant live with you?  Yes  No Work Phone: ( ) \_\_\_\_\_

Annual Income: \$ \_\_\_\_\_ Size of Family Unit: \_\_\_\_\_

Parent/Guardian signature: \_\_\_\_\_ Date: \_\_\_\_\_

*Signature verifies that information contained in this application form is complete and accurate AND understands if VSP denies voucher for any reason the Parent/Guardian is responsible for payment. PBO bares NO financial obligation.*

### *Income Verification*

(This section to be completed by a contact person from the Qualifying Agency, i.e. principal of the school where the vision screening was conducted.)

Qualifying Agency (School/ Head Start): \_\_\_\_\_

Contact Person: \_\_\_\_\_ Phone: ( ) \_\_\_\_\_

Contact Person's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

*Proof of income must be kept on file with the qualifying agency. Pay stub or tax return may be used for verification. Signature verifies that the information contained in this application form is complete and accurate.*

### *Prevent Blindness Oklahoma Office Use Only*

Date Application received: \_\_\_\_\_ Date voucher issued: \_\_\_\_\_

### *Screening Information*

Agency/ District: \_\_\_\_\_

Group Screened: \_\_\_\_\_

Screening Date: \_\_\_\_\_

### *Examination Information*

Date of exam: \_\_\_\_\_

Eye Doctor: \_\_\_\_\_

Phone: ( ) \_\_\_\_\_

**INSTRUCTIONS ARE ON THE BACK OF THE FORM**

**If you have any questions, please contact Prevent Blindness Oklahoma at 405/848-7123**

**Instructions for Completing the  
Application for Vision Service Plan Benefits**

**Applicant Information Section:**

Please fill in all of the information requested. If the child does not have a social security number, please indicate by writing N/A.

**Parent / Guardian Information Section:**

Please fill in all of the information requested.

**Verification Section:**

**Qualifying Agency:** Please write in the name of the location where Prevent Blindness Oklahoma conducted the vision screening.

**Contact Person:** Please print the name of the person from the qualifying agency who has verified that the information contained in the application is complete and accurate.

**Phone:** Please write in the qualifying agency contact person's phone number.

**Qualifying Agency signature/date:** Please have the qualifying agency contact person sign and date the application

**ATTENTION QUALIFYING AGENCY CONTACT PERSON:**

**Your signature verifies that the child meets the following guidelines:**

- ❖ **Family income is no more than 200% of the poverty level (see table)**
- ❖ **Child is NOT receiving Medicaid**
- ❖ **Child is 18 years old or younger (Note: Children who are 18 years old must still be attending high school)**
- ❖ **Child is a U.S. Citizen or resident alien**

<b>200% of Federal Poverty Guidelines for 2009</b>	
<b>48 Contiguous States &amp; D.C.</b>	
1	<u><b>\$21,660</b></u>
2	<u><b>\$29,140</b></u>
3	<u><b>\$38,620</b></u>
4	<u><b>\$44,100</b></u>
5	<u><b>\$51,580</b></u>
6	<u><b>\$59,060</b></u>
7	<u><b>\$66,540</b></u>
8	<u><b>\$74,020</b></u>
Each Add'l person <b>Add</b>	<u><b>\$ 7,480</b></u>

**Mail the completed application to Prevent Blindness Oklahoma, 6 N.E. 63<sup>rd</sup> St., Suite 150, Oklahoma City, OK 73105 or FAX to : 405-848-6935. If you have questions please call Kitty at 405 848-7123 ext 101.**