



SIGHT FOR STUDENTS APPLICATION

NOTE: Please fill in all sections completely before returning to Prevent Blindness Indiana. This form is available online at www.pbeye.org

Fax to Prevent Blindness Indiana at 317-815-9952

If you have any questions or need assistance completing this form, please contact Prevent Blindness Indiana toll-free at 800-232-2551 during normal office hours: Monday through Friday, 8:30 AM to 5:00 PM. If a parent/guardian is completing this form, please return the completed form to the school nurse/public health official for income verification. The school nurse/public health official will then submit this application to Prevent Blindness Indiana.

Student's Name _____ Date of Birth ____ / ____ / ____

Address _____ City _____

State _____ ZIP _____ Home Phone _____ Social Security Number* _____

*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**.

PARENT/GUARDIAN INFORMATION (PLEASE PRINT CLEARLY)

Name _____ Relationship to child _____

Does child live with you? Yes No

If No, Address _____

City _____ State _____ ZIP _____ Home Phone _____

County _____ Ethnicity _____ Sex _____

Is your child enrolled in Medicaid or any other vision insurance plan? Yes No (If yes, **not eligible for program**)

Annual Income \$** _____ Size of Family Unit _____ Work Ph _____

**Annual income must be provided to school nurse or public health official for verification to qualify for VSP assistance. The chart shown below (200% of Federal Poverty Guidelines-2007) will be used to determine eligibility.

SIZE OF FAMILY	POVERTY LEVEL 2007
1	\$20,420
2	27,380
3	34,340
4	41,300
5	48,260
6	55,220
7	62,180
8	69,500
Each Additional Person Add	6,960

AGENCY/ORGANIZATION/SCHOOL INFORMATION (PLEASE PRINT CLEARLY)

(To be completed by the school nurse or public health official – **not the parent**)

Agency/Organization/School Name _____

Address _____ City _____ State _____

ZIP _____ Work Phone _____ Fax _____ Email _____

Before sending this completed application to Prevent Blindness Indiana, please verify that the following criteria has been met by checking off each statement:

The family's income is no more than guidelines listed above (200% of poverty level).

Child is **NOT** enrolled in Medicaid or any other vision insurance.

Child is 18 years old or younger and has not graduated from high school.

Child or parent is US citizen or documented immigrant with a Social Security Number.

Child has **NOT** used the VSP Sight for Student's program during the last 12 months.

PLEASE MARK WHERE TO SEND:

**HOME
SCHOOL
AGENCY**

I, the undersigned, have verified the income shown above.

Signature _____

Date Signed _____

Written Name _____

Please allow 1-2 weeks for application processing.

Updated August 2007

FOR OFFICE USE ONLY

GC#	
Issue Date	
Access	