

VISION SERVICE PLAN - SIGHT FOR STUDENTS APPLICATION

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

Address _____ 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**.

City _____ State _____ ZIP _____ Home Ph _____

PARENT/GUARDIAN INFORMATION (PLEASE PRINT CLEARLY)

Name _____ Relationship to child _____

Does child live with you? Yes No

If No, Address _____

City _____ State _____ ZIP _____ Home Ph _____

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-2009) will be used to determine eligibility.

Size of Family	Poverty Level 2009	Size of Family	Poverty Level 2008
1	\$21,660	6	59,060
2	29,140	7	66,540
3	36,620	8	74,020
4	44,100	Each additional	
5	51,580	Person add	7,480

If you have any questions or need assistance completing this form, please contact Prevent Blindness Iowa toll-free at 800/329-8782 during normal office hours: Monday through Friday, 8:00 AM to 4:30 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 Iowa.

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 _____ Work Ph _____

City _____ State _____ ZIP _____ Fax Ph _____

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

Signature _____ Date Signed _____

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

- The family's income is no more than 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.

OFFICE USE ONLY

Issue Date _____ Voucher Expiration Date _____ Voucher Number _____

Prevent Blindness Iowa, 1111 Ninth Street, Suite 250, Des Moines, Iowa 50314-2585
515/244-4341 or toll-free 800/329-8782 Fax 515/ 244-4718 Email mail@preventblindnessiowa.org

Please allow 1-2 weeks for application processing. This form is available online at <http://www.preventblindness.org/iowa>