Prevent Blindness Wisconsin

OFFICE USE ONLY 6/20
Date: _____ Staff: ____
☐ Approved ☐ Denied
☐ HE ☐ S4S ☐ MEMO

Children's Vision Care Voucher Application

Please Return to: Prevent Blindness Wisconsin ● 731 N. Jackson Street ● Suite 405 ● Milwaukee, WI 53202
Fax: (414) 765-0377 ● Phone: (414) 765-0505 ● Breanna@pbwi.org

Applicant Information

My child needs: ☐ Glasses Only ☐ Eye Exam and Glasses

Child's Name: _____ **Date of Birth:** _____

Address: _____ **City:** _____

Zip: _____ **County:** _____ **Phone:** (_____) _____-_____

Parent/Guardian Name: _____

Vision Health Information

Has your child had an eye exam in the last 12 months? ☐ Yes ☐ No

Date of last eye exam: _____

Has your child broken or lost their glasses? ☐ Yes ☐ No

Has your child used a vision care voucher in the last 12 months? ☐ Yes ☐ No

If yes, please indicate the type of voucher used:

☐ VSP Sight for Students ☐ Healthy Eyes ☐ Other:_____

Financial and Insurance Information

Please provide at least **ONE** proof of income document: pay stub, tax return, Social Security Award Letter etc.

Does your child qualify for free or reduced price lunch? ☐ Yes ☐ No

Annual Household Income: $ _____ **# of people in household including yourself:** _____

Does your child have BadgerCare Plus (Medicaid) or other vision insurance? ☐ Yes ☐ No

*If your child has BadgerCare and needs an eye exam call 1-800-362-3002.

I attest that the above information is true to the best of my knowledge. I understand that if I provide incomplete or incorrect information I may be required to pay for the vision care services my child receives and my child may be declined service.

Parent/Guardian Signature: _____ Date: _____

To be completed by school/agency staff if applying through a school/agency.

Name of School/Agency : _____ Name of Contact: _____

Address: _____ City: _____

Zip: _____ Phone: _____ Email: _____

Send Voucher Information to: ☐ Applicant's Home ☐ School/Agency

Send Voucher Approval Letter in: ☐ English ☐ Spanish ☐ Hmong