Prevent Blindness Georgia®
Our Vision Is Vision™

APPLICATION FOR VISION SERVICE PLAN BENEFITS

Applicant Information

Name: _____ Date of: Birth: _____

Address: _____

_____ Social Security #:_____-_____-_____

City:_____ State: _____ Zip: _____ Phone: (____) _____-_____

Eligible for Medicaid or other vision insurance? ☐ Yes ☐ No

U.S. citizen? ☐ Yes ☐ No Resident Alien? ☐ Yes ☐ No High school graduate? ☐ Yes ☐ No

Parent/Guardian Information

Name: _____ Relation to Applicant: _____

Address: _____

_____ Social Security #:_____-_____-_____

City:_____ State: _____ Zip: _____

Home Phone: (_____) _____-_____ Work Phone: (_____) _____-_____ Does applicant live with you? ☐ Yes ☐ No

Financial Information for Applicant or Responsible Person

(Proof of income must be provided. Pay stub or tax return may be used for verification.)

Annual income: $_____ Proof of income attached: ☐ Pay stub ☐ TaxReturn

Qualifying Agency/Organization: _____ Size of Family Unit:_____

Certification

(The above financial information is correct to the best of my knowledge.)

Signature of Parent/Guardian: _____ Date:_____

Prepared by: _____ Position: _____

Follow-Up

BF #: _____ Issue Date: _____ Follow-Up Date: _____ Claim Date: _____

739 West Peachtree Steet, Suite 200, Atlanta, GA 30308-1137
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An affiliate of Prevent Blindness America

SIGHT FOR STUDENTS
A VSP Program

VSP Vision care for us

SUCCESS STORY

Vision correction can have a dramatic impact on a child's ability to learn, participate in sports, and form a positive self-image. Since you helped identify a child for this benefit, we ask your help in telling the story. We recognize the importance of patient confidentiality, so we will contact you and the family prior to sharing this story. However, please initial here _____ if you are open to sharing your story so we can be sure to follow up with you. If you are submitting on behalf of a family, please indicate if it is OK for us to contact the family directly by noting it here: Y N

***** *please print clearly* *****

Date: _____

Your Name: _____ Telephone: (____) _____

Your Organization: _____
Name *City* *State*

Child's Name: _____ Child's Age: _____

Parent/Guardian's Name: _____ Telephone: (____) _____

Email: _____ Preferred way of contact? _____

Why was child referred? *(select as many as apply)*

- ☐ Eyes that cross or point outward
- ☐ Frequent blinking, squinting, or rubbing eyes
- ☐ Holding books and objects unusually close
- ☐ Frequent complaints of eye discomfort, headaches, or dizziness

Date of eye exam: _____ Date of last eye exam:_____

If the child had never had an eye exam previously, did they participate in vision screenings at the school? _____

After the exam, vision correction had an impact on this child's ability to:

☐ learn ☐ participate in sports ☐ form a positive self-image ☐ get follow up care for a chronic disease

Other: _____

CHILD'S SUCCESS STORY

How has the eye exam and, if needed, glasses help you? Do you have more interest in learning, socializing, playing sports? Have you noticed an improvement in any areas? Do you like what your glasses look like? *(use reverse or separate sheet if necessary)*

_____

_____

_____

_____

_____

If possible, please also send examples of photos, school work, etc.

Please send to: VSP Sight for Students/MS 231
P. O. Box 997100
Sacramento, CA 95899-9989

Fax: (916) 858-5388