Prevent Blindness Georgia
270 Carpenter Drive, Suite 606
Atlanta, GA 30328-4931
Phone 404.537.4988
www.pbga.org

Dear Sir/Madam,

Prevent Blindness Georgia administers various second-party vision care assistance programs. Those organizations have set eligibility requirements with which we must strictly adhere in order to ensure that the limited resources available are directed to individuals most in need of the programs' benefits.

Please note that vouchers are not always available in every county. For some counties, Prevent Blindness Georgia may offer vision exams and access to glasses at our community-based vision clinics.

Also note that due to the charitable nature of this program, we assist only those that ***do not*** have access to vision care at all. If you have a co-pay or a spend-down that is required with your vision coverage, you may be ineligible for this program.

If you ***do not*** have vision care coverage, please complete this application so that we may determine for which programs you (or your child) may qualify. ***Please read this application in its entirety.*** Please send ***copies*** of ***all*** requested documents so as not to delay processing. Originals cannot be returned. You will be notified of your eligibility via email or telephone within 4 weeks of receipt of your application.

Email or mail completed form and documents to:

Prevent Blindness Georgia
Vision Care Assistance Programs
c/o De Nichols
270 Carpenter Dr., Ste. 606
Sandy Springs, GA 30328
Email: *visionoutreach@pbga.com*

Remember to include a copy of your current eyeglasses prescription if you already have a prescription.

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This application is for Georgia Adult residents only
Please read entire application before signing.

Services needed: ◯ Eye Exam & glasses ◯ glasses only *(please send copy of current prescription)*

Date of last exam: _____

_____ _____
Name (please print) Date of birth

_____ _____
Street address City, State, Zip

_____ _____
Primary phone Alternate phone#

_____ _____
Number of people in your household (Including yourself) Email Address

Please select which type of insurance you have.
◯ Medicaid ◯ Medicare ◯ State coverage
◯ Vision coverage through employer ◯ Supplemental coverage (i.e. AARP, Humana, etc.) ◯ Veteran's Benefits
◯ None ◯ Other (please describe) _____

What is the ***Total*** Yearly family income (i.e. ***ALL*** household income including spouse's income, dependent income, etc.)?

$_____

***A combination of (2) TWO* of the following types of proof of income are REQUIRED. Applications WILL NOT be processed without (2) TWO types of proof of income. Proof of income or a *NOTARIZED* document may come from you or someone that may provide financial assistance to you, explaining their assistance. It may also come from an organization (on their letterhead) that is referring you if you have no income. Please note that all applications sent WITHOUT appropriate income verification will not be processed.**

Proof of income includes:

- **Last year's W2**
- **Last 2 months of bank statements = 1 proof of income**
- **2 current paycheck stubs = 1 proof of income**
- **Social Security Administration Award Letter.**
- **Unemployment Claim/Wage Inquiry statement**
- ***ANY* information regarding financial circumstances, including monthly amounts received on *ANY* other sources of income (ex: TANF, pension, retirement, child support, food stamps, part time employment, etc.)**

I attest that the above information is true to the best of my knowledge:

Signature_____ Date_____

Please mail or email applications to:

Prevent Blindness Georgia, Ste. 600
Sandy Springs, GA 30328
Attn: De Nichols
Email: visionoutreach@pbga.org
Phone # 404-537-4988

Please allow 4 weeks for processing.