





APPLICATION FOR PROGRAM SERVICES


Providing Free Comprehensive Eye Exams & Glasses


2009-2010


Parents: Fill out information on boxes 1-4 and return completed application to the nurse, once approved you will receive this application back to take to your appointment as a voucher. If approved, contact the doctor on box 6 to schedule an appointment.



| | | |
|---|---------------------|---|
| 1 | Student Information |  |
| Full Name: _____ | | |
| Birth date: ____/____/____ | | |
| Sex: Male ___ Female ___ Grade: _____ | | |
| Race/ Ethnic Origin:(for research purpose only) | | |
| Hispanic/Latino: ___ Black/African American ___ | | |
| White: ___ Asian: ___ Other: _____ | | |
| Visual Acuity: Aided: RE 20/____ LE 20/____ Unaided: RE 20/____ LE 20/____ | | |

| | | |
|-----------------------------|------------------------------|---|
| 2 | Parent/ Guardian Information |  |
| Name: _____ | | |
| Signature: _____ | | |
| Home Address: _____ | | |
| City: _____ Zip Code: _____ | | |
| (1) Phone: _____ | | |
| (2) Phone: _____ | | |

| | | |
|---|-------------------------------|---|
| 3 | Student Insurance Information |  |
| Is your child insured: Yes ___ No: ___ | | |
| If yes, indicate which insurance: | | |
| ___CHIP ___Medicaid ___Private ___None | | |
| If you have indicated that your child does not have insurance, Eye Care for Kids and Children's Defense Fund will assist you in applying for these benefits. (See Instruction Page) | | |
| <i>"I authorize Eye Care for Kids to release my name and phone number to Children's Defense Fund to apply for CHIP/Medicaid for my child."</i> | | |
| Signature: _____ Date: _____ | | |

| | | |
|---|---------------------------|---|
| 4 | Family Income Information |  |
| Monthly Household Income: \$ _____ | | |
| Other Income: \$ _____ | | |
| (Include: child support, government assistance, alimony) | | |
| Number of adults living in household: _____ | | |
| Ages: _____ | | |
| Number of other members in household: _____ | | |
| Ages: _____ | | |
| Is this student on free or reduced lunch?: Yes ___ No ___ | | |

| | | |
|--|---------------------------------|---|
| 5 | Nurse/Social Worker Information |  |
| I recommend services for the student as explained above: | | |
| Name/Title: _____ | | |
| School: _____ | | |
| School Address: _____ | | |
| City: _____ Zip Code: _____ | | |
| School District: _____ | | |
| Phone: _____ Fax: _____ | | |

| | |
|-------------------------------|--|
| 6 |  Call the number below For an appointment.  |
| APPLICATION NOT YET APPROVED. | |