



Dear Parent/Guardian:

Prevent Blindness has been designated as a community partner with Visionworks/Davis Vision to issue eye exam and eyeglass vouchers to qualifying children through their *Let's Go See* campaign. **TO APPLY FOR SERVICES, SUBMIT THIS COMPLETED APPLICATION TO THE PREVENT BLINDNESS TEXAS OFFICE LISTED BELOW.** Please print or type legibly. Incomplete applications will not be processed. Please allow 2-3 weeks to process your application.

SECTION I: CHILD'S GENERAL INFORMATION (PLEASE PRINT OR TYPE)

Child's Name (First, Middle, Last): _____

Check **ONLY** one box to indicate the service you are requesting: ☐ Eye Exam & Eyeglasses ☐ Eyeglasses Only

Date of Birth (Month/Day/Year): _____ / _____ / _____ Age: _____ Sex: ☐ Male ☐ Female

Social Security Number (if applicable): _____ - _____ - _____ Race: _____

Mailing Address: _____ Apt. #: _____

City: _____ State: _____ Zip: _____ County: _____

Referring Agency/School (if applicable): _____ Contact Phone: _____

SECTION II: PARENT/GUARDIAN INFORMATION (PLEASE PRINT OR TYPE)

Parent/Guardian Name: _____ Relation to Child: _____

Phone Number: _____ Email Address: _____

SECTION III: CHILD'S ELIGIBILITY AND BACKGROUND INFORMATION

1. Has the child failed a vision screening? ☐ Yes ☐ No
2. Please select which type of insurance the child has (if any):
☐ None ☐ Medicaid ☐ Medicare ☐ CHIP ☐ Vision Coverage through Employer
☐ Other (please describe): _____
3. Is the child enrolled in the School Free and Reduced Lunch Program? ☐ Yes ☐ No
4. What is the total ANNUAL household income? \$ _____
5. What is the number of ALL persons in the household? _____

SECTION IV: PARENT/GUARDIAN AGREEMENT (PLEASE READ AND SIGN BELOW)

All information on this application is kept in the strictest confidence by Prevent Blindness Texas, Prevent Blindness America and agencies associated with our programs. By signing below, I attest that the above information is true and complete to the best of my knowledge.

PARENT/GUARDIAN SIGNATURE: _____ **DATE:** _____

PLEASE RETURN THIS COMPLETED APPLICATION BY MAIL OR FAX TO:

Mail: Prevent Blindness Texas, Southeast Texas Region, 2202 Waugh Drive, Houston, TX, 77006

Fax: (713) 529-8310

FOR PREVENT BLINDNESS TEXAS OFFICE USE ONLY

Voucher Number: _____	Voucher Mailed To: <input type="checkbox"/> Parent <input type="checkbox"/> Agency/School	Issue Date: _____	Authorized By: _____
------------------------------	--	--------------------------	-----------------------------