Prevent Blindness Texas

Healthy Eyes Eyeglass Program
CLIENT APPLICATION FORM

The *Healthy Eyes Eyeglass Program* provides **EYEGLASSES ONLY** to those clients who qualify. In order to qualify for this program, there are certain eligibility criteria that must be met. The following questions will determine if you qualify. **TO APPLY FOR THIS SERVICE, SUBMIT THIS COMPLETED APPLICATION ALONG WITH A COPY OF YOUR CURRENT EYE PRESCRIPTION THAT MUST BE LESS THAN ONE YEAR OLD.** Please print or type legibly. Incomplete applications will not be processed. **Please allow 3-6 weeks to process your application.**

SECTION I: CLIENT GENERAL INFORMATION (PLEASE PRINT OR TYPE)

First Name:_____ Last Name:_____

Date of Birth (Month/Day/Year):____/____/____ Age:_____ Race:_____ Sex: ☐ M ☐ F

Mailing Address:_____

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

Phone Number:_____ Email Address:_____

SECTION II: CLIENT ELIGIBILITY AND BACKGROUND INFORMATION

1. Have you failed a vision screening? ☐ Yes ☐ No
2. Are you enrolled in Medicare? ☐ Yes ☐ No
3. Are you enrolled in Medicaid? ☐ Yes ☐ No
4. Are you receiving Veteran's Benefits? ☐ Yes ☐ No
5. If you are receiving other financial assistance for your eye care, please indicate here:_____
6. Do you have a current prescription (less than 1 year old) for eyeglasses? ☐ Yes ☐ No
7. Have you received support from the OneSight program previously? ☐ Yes ☐ No
   a. **If yes**, has there been a change in your prescription or have you damaged your eyeglasses? ☐ Yes ☐ No
8. What is the **YEARLY** household income? $_____
9. What is the **TOTAL** number of members living in the household (include parents and children)? _____

SECTION III: CLIENT 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 information indicated above is true and complete to the best of my knowledge. Please note that should you be eligible for this program, your OneSight voucher will be limited to the following restrictions:

- One voucher per person.
- The voucher does not include an eye exam. You must have a prescription that was written no longer than one year ago.
- The recipient chooses from a special assortment of frames. Availability may vary.
- Multifocals will be limited to traditional flat-top bifocal. No-line bifocals and/or tinting services are unavailable.
- All children up to age 12 will receive polycarbonate lenses.
- Breakage Protection Plan is not applicable. Due to the charitable nature of this program, neither Luxottica nor OneSight will provide warranty or guarantee on the eyeglasses if they are stolen or lost.
- Under no circumstances will upgrades on frames and/or lenses be permitted.

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

PLEASE SUBMIT APPLICATION VIA MAIL OR FAX TO: 2202 Waugh Dr., Houston, TX 77006 OR 713-529-8310.

FOR PREVENT BLINDNESS TEXAS OFFICE USE ONLY	
Date Application Received:	**Date Voucher Distributed:**