

VSP Application for Free Eye Exam and Glasses
(Please complete application)

Applicant (Child's) Information (Please Print)

Name: _____ Date of Birth: _____
Address: _____ Social Security #: _____ - _____ - _____
City: _____ State: _____ Zip: _____ Phone: (____) - _____ - _____

Parent/Guardian Information (Please Print)

Name: _____ Relation to Applicant: _____
Address: _____ Social Security #: _____ - _____ - _____
City: _____ State: _____ Zip: _____ Does Applicant Live With You?
() Yes () No
Home Phone: (____) - _____ - _____ Work Phone: (____) - _____ - _____

Financial Information for Applicant or Responsible Person

*(Proof of income must be provided. Copy of tax return may be used for verification)
(If child qualifies for free or reduced lunch, a letter verifying their qualification may be used)*

Annual Income: \$ _____ Number of people in family unit: _____

(please see cover letter for additional information regarding proof of income)

Certification

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

Parent/Guardian: _____ Date: _____
(Signature)

Prepared by: _____ Position: _____
(Signature)

Please return to:
PREVENT BLINDNESS TENNESSEE
95 White Bridge Road, Suite 312
Nashville, TN 37205
1-800-335-0450 or (615) 352-0450
Fax (615) 352-5750



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Your signature below indicates the following criteria have been met for all children applying.
Please indicate if the voucher should be sent to the school or the parent.

The eligibility criteria are:

- ❖ Family income is no more than 200% of the federal poverty level (please see chart below for income requirement)
- ❖ Child is not eligible for Medicaid and does not have TennCare or other vision insurance (TennCare offers a free eye exam and glasses annually to children under age 21)
- ❖ Child is 18 years old or younger or has not graduated from high school
- ❖ Child or parent is a U.S. citizen or documented immigrant with a social security number
- ❖ Child has not received glasses from this program during the past 24 months.

Date _____ School _____

Address _____

Phone # _____ Contact Name _____

Your Relationship to the applicant _____

Contact Signature _____

Financial Guidelines:

Size of Family	Monthly Income
1	\$1,805
2	\$2,428
3	\$3,052
4	\$3,675
5	\$4,298
6	\$4,922
7	\$5,545
9	\$6,168
For each additional person add:	\$623

Source: VSP Sight for Students Program 2009

