Prevent Blindness Texas

Sight for Students Program
CHILD APPLICATION FORM

Prevent Blindness Texas provides eye care services to children who qualify, which may include an eye exam, glasses and/or other eye care treatment needs. To qualify, there are certain eligibility criteria that must be met. The following questions will determine if your child qualifies. Please answer all the questions and return the application to the contact information listed below. Please print legibly or type. Incomplete applications will not be processed. Please allow 2-3 weeks to process your application.

SECTION 1: CHILD GENERAL INFORMATION (PLEASE PRINT OR TYPE)

First Name:_____ Middle Initial:_____ Last Name:_____

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

Mailing Address:_____ Apt/Lot #:_____

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

Ethnicity: ☐ African American ☐ Asian ☐ Caucasian ☐ Hispanic/Latino ☐ Native American ☐ Other:_____

How did you hear about us? ☐ Vision Screening ☐ PBT Website ☐ School ☐ Community Agency ☐ Other:_____

SECTION 2: PARENT/GUARDIAN INFORMATION (PLEASE PRINT OR TYPE)

Parent/Guardian Name:_____ Relationship to Child:_____

Phone Number:_____ Email:_____

Total Number of People in Household (Adults and Children):_____ Annual Household Income: $_____

☐ I DO NOT CONSENT ☐ I DO CONSENT to receive electronic communications by: ☐ Text ☐ Email ☐ Both

SECTION 3: REFERRAL AGENCY INFORMATION (PLEASE PRINT OR TYPE)

Agency Name:_____ Agency Advocate:_____

Agency Mailing Address (Street, City, Zip):_____

Advocate Phone:_____ Advocate Email:_____

Preferred Mailing Address (if child is eligible to receive services): ☐ Parent/Guardian ☐ Referral Agency

SECTION 4: CHILD'S ELIGIBILITY INFORMATION

1. Has the child received a vision screening at a school, well-child visit, or community event? ☐ Yes ☐ No
2. Does the child have a current eye exam prescription (less than 1 year) for eyeglasses? ☐ Yes ☐ No
   If YES, please include a copy of the child's current eye prescription.
3. What type of insurance coverage does the child have? (check all that apply)
   ☐ Uninsured ☐ Medicaid ☐ CHIP ☐ County/City ☐ Private ☐ Other:_____
   a. If insured, does the child's insurance cover any of the following? ☐ Eye Exams ☐ Eyeglasses ☐ Both
4. Has the child received assistance from Prevent Blindness Texas previously? ☐ Yes ☐ No
5. Is the child enrolled in the School Free and Reduced Lunch Program? ☐ Yes ☐ No

SECTION 5: PARENT/GUARDIAN AGREEMENT (PLEASE READ AND SIGN BELOW)

All information on this application is kept in the strictest confidence by Prevent Blindness Texas (PBT), Prevent Blindness and agencies associated with our programs. I authorize PBT to disclose my child's personal information listed above, and health information, related to the results of subsequent eye care, to be shared with Prevent Blindness, PBT, and third-party referral programs for purposes related to follow up and statistical analysis. By signing below, I certify that the information indicated above is true and complete to the best of my knowledge.

Please note that if your child is eligible, this program will be limited to the following restrictions:

- One voucher per child in a 12-month period.
- The voucher must be redeemed at participating partners designated by Prevent Blindness Texas.
- Elective contact lenses are not covered.
- Lost, stolen, or broken glasses will not be covered or replaced.

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

PLEASE MAIL OR FAX APPLICATION TO: 2180 North Loop West, Suite 435, Houston, TX 77018 OR 713-529-8310

FOR PREVENT BLINDNESS TEXAS OFFICE USE ONLY			
Referred By: ☐ PBT Vision Screening ☐ School ☐ Partner Agency		**Voucher Referral Program:** ☐ VSP ☐ HE ☐ TF ☐ Other	
Date App Received:	**GC Number:**	**Date Voucher Distributed:**	**Distributed By (Initials):**