Prevent Blindness Texas

# Am EYE Healthy? Program
# ADULT APPLICATION FORM

Prevent Blindness Texas provides eye care services to those clients who qualify. To qualify, there are certain eligibility criteria that must be met. The following questions will determine if you qualify. 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 3-6 weeks to process your application.

## SECTION 1: CLIENT 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:_________________________

Phone Number:________________________________________Email:_________________________________________

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

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

How did you hear about us? ☐ Vision Screening ☐ PBT Website ☐ 211 Texas ☐ Community Agency ☐ Other:__________

## SECTION 2: 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 client is eligible to receive services): ☐ Client ☐ Referral Agency

## SECTION 3: CLIENT ELIGIBILITY INFORMATION

1. Have you received a vision screening by Prevent Blindness Texas? ☐ Yes ☐ No
2. Do you have a current eye exam prescription (less than 1 year) for eyeglasses? ☐ Yes ☐ No
   If YES, please include a copy of your current eye prescription.
3. What type of insurance coverage do you have? (check all that apply)
   ☐ Uninsured ☐ Medicaid ☐ Medicare ☐ County/City ☐ Private ☐ Veterans Benefits ☐ Other:______________
   a. If insured, does your current insurance cover EYE EXAMS? ☐ Yes ☐ No
   b. If insured, does your current insurance cover EYEGLASSES? ☐ Yes ☐ No
4. Have you received assistance from Prevent Blindness Texas previously? ☐ Yes ☐ No

## SECTION 4: CLIENT 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 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 you are eligible, this program will be limited to the following restrictions:**

- One voucher per person in a 12-month program period.
- The voucher must be redeemed at participating partners designated by Prevent Blindness Texas.
- The recipient chooses from a special assortment of frames. Availability may vary.
- The program includes single vision or lined bifocal lenses. No-line bifocals and/or tinting services are unavailable.
- Breakage Protection Plan is not applicable. Due to the charitable nature of this program, there is no warranty or guarantee on the eyeglasses if they are lost, stolen, or broken.
- Under no circumstances will upgrades on frames and/or lenses be permitted, or the voucher will be voided.

**CLIENT 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 | | |
|---|---|---|
| **Participant ID:** | **Voucher Referral Program:** ☐ UH ☐ HE ☐ VSP ☐ VSPGL ☐ TF ☐ Other | |
| **Date App Received:** | **Date Voucher Distributed:** | **Distributed By (Initials):** |