



225 W. Wacker Drive
Suite 400
Chicago, IL 60606

[800] 331.2020 toll free
[312] 363.6001 local
www.preventblindness.org

Dear Sir/Madam,

Prevent Blindness administers various second party vision care assistance programs. Those organizations have set eligibility requirements which must be strictly adhered to in order to ensure that individuals are truly in need of the benefits from the programs.

Please note that due to the charitable nature of this program, we assist those that **do not** have access to vision care at all. If you have a co-pay or a spend down that is required with your vision coverage, you are ineligible for this program.

If you **do not** have vision care coverage, please complete this application so that we may determine which of the programs you (or your child) may be qualified for. **Please read this application in its entirety.** Please send **copies** of **all** requested documents so as not to delay processing. Originals cannot be returned. **You will be notified of your eligibility by mail within 6 -8 weeks of receipt of your application.**

Mail or fax completed form to:

Prevent Blindness
Vision Care Assistance Programs c/o Tasha Lockridge
225 W. Wacker Drive, Suite 400
Chicago, IL 60606
Fax: (312) 363-6052

Office Use Only: m/d_____ gc#_____

Please read entire application before signing.

Services needed: ☐ Eye Exam & glasses ☐ glasses only

Date of last exam: _____

Name (please print)

Date of birth

Street address

City, State, Zip

Primary phone

Alternate Phone#

Number of people in your household (Including yourself)

Email address

Please select which type of insurance you have.

- ☐ Medicaid ☐ Medicare ☐ State coverage (i.e. MediCal, TennCare, AHCCCS, but not limited to these)
☐ Vision coverage through employer ☐ Supplemental coverage (i.e. AARP, Humana, etc.) ☐ Veteran's Benefits
☐ None ☐ Other (please describe) _____

What is the **Total** Yearly family income (i.e. **ALL** household income, spouse's income, dependent income etc.)?

\$ _____

A combination of (2) TWO of the following proofs of income are REQUIRED. Applications WILL NOT be processed without (2) TWO proofs of income or a NOTARIZED document stating absence of income. Proof of income or a NOTARIZED document may come from you or someone that may provide financial assistance to you, explaining their assistance. It may also come from an organization (on their letterhead) that is referring you if you have no income. Please note that all applications sent WITHOUT appropriate income verification will be sent back automatically without exception.

Proof of income includes:

- Last year's W2
- Last 2 months of bank statements = 1 proof of income
- 2 current pay check stubs = 1 proof of income
- Social Security Administration Award Letter.
- Unemployment Claim/Wage Inquiry statement
- **ANY** information regarding financial circumstances, including monthly amounts received on **ANY** other sources of income (ex: TANF, pension, retirement, child support, food stamps, part time employment, etc.)

I attest that the above information is true to the best of my knowledge:

Signature _____

Date _____

Please mail or fax applications to:

Prevent Blindness
225 W Wacker Drive #400
Chicago, Illinois 60606
Attn: Tasha Lockridge
Phone: 800-331-2020 x 126 Fax: 312-363-6052

**Please allow 6 to 8 weeks
for processing. All
correspondence regarding
this program is done **VIA**
MAIL ONLY.**