# TEMPLATE APPLICATION FOR VSP *SIGHT FOR STUDENTS* GIFT CERTIFICATE

As a suggestion, you can make a copy of this document to serve as your "master form" and reuse as you need it.

Applicant Information (PLEASE PRINT) ***All information below must be completed to process application. Incomplete applications cannot be processed:***

Name:_____ Date of Birth:_____

Address:_____

City:_____ State: Ohio Zip:_____ Phone:(_____)_____

Social Security#_____ - _____ - _____ County of Residence:_____
(Or one of the parents social security #) (If there is no social security number, contact the Children's Vision Coordinator for other options that may be available)

Parent/Guardian Information (PLEASE PRINT)

Name:_____

Address:_____

City:_____ State: Ohio Zip:_____ Home Phone:_____

Relationship to Applicant:_____ Work Phone:_____

Financial Information for Applicant (PLEASE PRINT) ***The information below must be completed to process application***

Annual Income:$_____ Family Size:_____ Income Meets Criteria? □ Yes □ No

Is the Applicant Enrolled in Medicaid or Other Vision Insurance? □ Yes □ No

***If YES, please explain***_____

_____

Is applicant is willing to write-up and send a *Sight for Students* Success Story? □ Yes □ No

***NOTE:*** Applications will not be processed unless all information is complete.

***NOTE:*** Applications will be accepted from the referring partner agency only. If this paper application is mailed to Prevent Blindness, it will not be accepted - - No one will be called and the application will be destroyed.

***NOTE:*** *Gift certificates will be mailed directly to the referring partner agency advocate. Gift certificates will not be mailed to the client.*

**ALL APPLICATIONS MUST BE RETURNED TO THE AGENCY ADVOCATE WHO GAVE YOU THIS APPLICATION**
**Do not mail this application to Prevent Blindness as it will not be processed**

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*Revised November, 2016*