

Please Print Clearly

Child Applicant Name: _____ Age: _____

Date of Birth: ____/____/____ Sex: _____ Social Security Number: ____-____-____

Guardian Name: _____ relation: _____ SSN: ____-____-____

Mailing Address: _____ Phone: (____)____-____

Please include apartment number.

City: _____ ST: _____ Zip: _____ Cell Phone: (____)____-____

Referral Information

Referring Agency: _____ Phone: _____

Contact Person: _____ Fax: _____

Qualification Information

Guardian Marital Status (Circle One): Single Married Divorced Separated Widowed

Date of child's last eye exam at a doctor's office: _____ Prescription Given?

____ (Y or N)

Has this child worn prescription glasses in the past 5 yrs? _____

***** Please attach a COPY of your dated prescription if less than one year old. *****

Does this child have medical Insurance? _____ Part / Program? _____

(Chips, Medicaid, Carelink, Other) (A, B, QMB, MQMB)

***** Please provide a copy of your insurance card. Note: We do not accept Superior or Star Plus. *****

Does insurance include eye exams? _____ Does insurance include glasses? _____

What is your need: _____ Eye Exam _____ Eye Glasses _____ Both Eye Exam and Glasses

Financial Information

YOU MUST INCLUDE A COPY OF ONE OFFICIAL DOCUMENT FROM THE LIST

BELOW FOR EACH MEMBER OF THE HOUSEHOLD OVER 18 YRS.

Applications will not be considered if written proof of income is not attached.

Current Tax Return (1040, p.1) Preferred

Payroll Stubs for past 2 months

Food Stamp Authorization Letter

Parole/Release Letter

If you do not have 1-4 listed previously;

Statement of resources for food, shelter, & transportation on official letterhead

Not Acceptable: Child Support or Bank Statements

Total Household Income: \$_____ **MONTHLY** Are you employed?

How often do you get paid? (Circle One) Weekly Bi-Monthly Monthly.

Including yourself, how many people live at the same address? _____

Please list all individuals living at this address.

Name	Age	Employed	Monthly Income	Employer/\$ Source
		Y or N	\$ (include proof)	
		Y or N	\$ (include proof)	
		Y or N	\$ (include proof)	
		Y or N	\$ (include proof)	
		Y or N	\$ (include proof)	
		Y or N	\$ (include proof)	

Bills	Amount
House Phone Bill	\$ /month
Cell Phone(s) Bill	\$ /month
Electric Bill	\$ /month
Water Bill	\$ /month
Cable Bill	\$ /month
Car Payment	\$ /month
Mortgage or Rent	\$ /month
Paid Child Support	\$ /month
Other -	\$ /month

Income Source	Amount
Employment (all)	\$ /month
Disability	\$ /month
SSI	\$ /month
Social Security	\$ /month
TANF/Food Stamps	\$ /month
Received Child Support	\$ /month
Other -	\$ /month
	\$ /month
	\$ /month

Documents to Include

Please include the necessary documents listed below. Originals cannot be returned.

ALL sections of this Application must be completed

Copies of **ALL** household income

Explanation of resources for food, shelter, & transportation (if not included above)

Clear copy of Drivers License and Social Security Card on the same page

Copy of Current Mailing Address in print form on a Utility Bill or Drivers License

Attach a COPY of dated eye prescription, if less than one year old only

Please read and sign below.

I give permission to verify any information listed above. **I understand that this is a gift and I should express my gratitude to the donating doctor or optical store. This application will not be processed until all qualifying documents are received.**

If approved, you will receive an approval letter, in 3-6 weeks.

Guardian Signature: _____

Date:

Children 18 years of age and younger ONLY
One applicant per form. Please make copies as necessary. Originals cannot be returned. All sections must be completed.

Mail this completed application to:

I Care Vision Center · One Haven for Hope Way · San Antonio, TX 78207
Phone (210) 220-2370 · Fax (210) 220-2499

Children 18 years of age and under ONLY
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Child Application for Vision Services

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