Public Health

Wayne County Health Department
Application for Vision Service Plan Benefits

Applicant Information (Please Print) ***Information below must be completed to process application:***

Name: _____ **Date of Birth:** _____

Address: _____

City: _____ **State:** Ohio **Zip code:** _____ **Social Security #:** _____

Township of Residence: _____ **County of Residence:** _____

Parent/Guardian Information (Please Print)

Name: _____ **Date of Birth:** _____

Address: _____

City: _____ **State:** Ohio **Zip code:** _____ **Phone:** _____

Relationship to Applicant: _____

Financial Information for Applicant (Please Print) *Information below must be completed to process application*

Annual Income $_____ **Family Size:** _____

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

If YES, please explain _____

_____

Is applicant willing to contribute a *Sight for Students* Story of Success? □ Yes □ No

Signatures verify that the information contained in this application form is complete and accurate:

Parent/Guardian Signature: _____ **Date:** _____

_____**STOP**_____

Partner agency Signature: _____ **Date:** _____

Partner agency Information: Wayne County Health Department
203 S. Walnut Street
Wooster, Ohio 44691
330-264-9590 330-262-2538 (fax)

Agency contact name: Tami Bucklew **Email:** TBucklew@wayne-health.org

NOTE: Applications will not be processed unless information is complete
NOTE: Do not schedule an examination appointment until the voucher is received

Please mail/email the completed application to the contact information above