Public Health
Prevent. Promote. Protect.

WAYNE COUNTY HEALTH DEPARTMENT

Nicholas Cascarelli, Ed.D. *Health Commissioner* **Eric A. Smith, MD** *Medical Director*

APPLICATION FOR VISION SERVICE PLAN BENEFITS

All information must be completed to process application

Applicant (Please Print)

Name:_____Date of Birth: _____

Address: _____

City:_____ State: Ohio Zip Code:_____Gender:___

Township of Residence:_____County of Residence:_____

Parent/ Guardian (Please Print)

Name:_____Date of Birth: _____

Address:_____

City:_____State: Ohio Zip Code:_____Phone:_____

Relationship to Applicant:_____

Financial Information for Applicant (Please Print) (family income for dependents)

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**_____

Vital Statistics – Community Health Services - WIC
203 S. Walnut St. Wooster, OH 44691
Phone: (330) 264-9590
Fax: (330) 262-2538
info@wayne-health.org

Environmental Health
428 W. Liberty St. Wooster, OH 44691
Phone: (330) 264-2426
Fax: (330) 262-8433
ehinfo@wayne-health.org

By signing below, I understand that due to the charitable nature of this program that the services the applicant receives are limited in an effort to serve as many people as possible who need eye care. I understand that I can only utilize this program every 2 (two) years for an eye exam. I understand that I am only eligible to receive eyeglasses this one time, unless there has been a significant change in my prescription or my eyeglasses have been damaged beyond repair. Further, I agree that when I visit the eye care professionals to attend my eye exam and/or obtain my eyeglasses that I will not be late to the eye appointment, will dress appropriately, and will exhibit appropriate behavior. I will be courteous and respectful at all times while on the premises. I understand that if I do not comply with any of the terms listed above, that the eye care professionals involved reserve the right to refuse their services and I could be asked to leave the premises immediately. I also authorize the disclosure of my eyeglasses prescription (if prescribed) to Prevent Blindness Ohio. In addition, Signatures verify that the information contained in this application form are complete and accurate.

Parent/Guardian Signature:

_____Date:_____

**********STOP**********

Partner Agency Signature: _____Date:_____

Partner Agency Information: Wayne County Health Department
Attn: VSP
203 S. Walnut St.
Wooster, OH 44691
Phone: 330-264-9590 x-214 Fax: 330-262-2538

Agency Contact Name: Beth Westfall email: bwestfall@wayne-health.org

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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/fax completed application to contact person listed above