



WAYNE COUNTY HEALTH DEPARTMENT

Nicholas V. 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 Information (Please Print)

Name: _____ Date of Birth: _____

Street Address: _____

City: _____ State: Ohio Zip Code: _____ Gender: _____

Township of Residence: _____ County of Residence: _____

Parent/ Guardian Information (Please Print)

Name: _____ Date of Birth: _____

Street 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 - WIC

244 W. South 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

The Wayne County Health Department is an Equal Opportunity Employer and Provider

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: _____

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 below

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

Partner Agency Signature: _____ Date: _____

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

Agency Contact Name: Mindy Watson email: mwatson@wayne-health.org

Income Guidelines for 2024

Family Size	Monthly Income	Annual Income
1	2,510.00	30,120.00
2	3,406.00	40,880.00
3	4,303.00	51,640.00
4	5,200.00	62,400.00
5	6,096.00	73,160.00
6	6,993.00	83,920.00
7	7,890.00	94,680.00
8	8,786.00	105,440.00
For each additional person add	897.00	10,760.00