NEW EYES
glasses for those in need

New Eyes Eyeglass Voucher Application Form

To be eligible for a voucher, applicants must:

1. Prove financial need (income at or below U.S. federal poverty guidelines) and provide proof of income or government assistance to Agency for verification.
2. Have had an eye exam within the past 12 months. Copy of prescription must be included.
3. Have no other resources to pay for glasses (including insurance, federal/state programs, other charitable support).
4. Have not received a New Eyes' voucher within the past 24 months.

Please print clearly. Fully complete all sections. Incomplete and unsigned applications will not be processed and cannot be returned. You should allow up to 6 weeks for a voucher to be issued.
The voucher will be mailed to the agent listed below, not to the applicant.
Vouchers expire within 90 days of issuance.

ALL FIELDS MUST BE COMPLETED. DO NOT LEAVE BLANK OR APPLICATION WILL BE DISCARDED.

Agency Information

(Applicant's case worker, social worker, health clinic or primary care doctor; NOT an eye doctor)

Agency Name _____ Phone # _____

Agency Address _____

City _____ State _____ Zip Code _____

Agency Representative Name _____ Email _____

(**MANDATORY)** Agency Tax ID: _____ *Agent signature required on page 2.*

Applicant Information

Applicant Name _____ Phone # _____

Date of Birth _____ Age_____Sex ____ If a Minor, Parent/Guardian's Name _____

Address _____Email _____

City _____ State _____ Zip Code _____

Occupation _____ Employer _____

County_____

Do you have: Private Health Insurance? Medicare? Medicaid? Other Public Assistance? (circle all that apply)

(Application form continued on page 2)

Mail completed form and **COPY** of eyeglass prescription to:

New Eyes • P.O. Box 332 • Short Hills, NJ 07078

Phone 973.376.4903

www.new-eyes.org

YOUR FINANCIAL SUMMARY

Number of Family Members Living in the Household: # Adults____# Children___

Monthly Household Income		**Average Monthly Household Expenses**	
Applicant's Take-home Pay	$_____	Rent/Mortgage	$_____
Spouse's Take-Home Pay	$_____	Food	$_____
Parent/Guardian's Take-Home Pay	$_____	Utilities	$_____
Social Security Benefits	$_____	Telephone/Cell Phone	$_____
Disability Benefits	$_____	Medical Expenses	$_____
Retirement/Pension Benefits	$_____	Car/Transportation	$_____
Veteran's Benefits	$_____	Insurance: Medical	$_____
Unemployment Benefits	$_____	Home	$_____
Federal or State Public Assistance	$_____	Life	$_____
Child Support/Alimony	$_____	Credit Card Payments	$_____
Food Stamps	$_____	Child Care	$_____
Other Income	$_____	Other Expenses	$_____
Total Monthly Income	**$_____**	**Total Expenses**	**$_____**

I verify that the financial information provided by this applicant is accurate.

Signature of Agency Representative (as named on page 1**)** **Date**

IMPORTANT – PLEASE COMPLETE BELOW.

1. Please explain any unusual financial situation or other circumstance that might be helpful in reviewing this application.
2. Please tell us how a new pair of eyeglasses might make a difference to your life.

Attach an additional sheet if necessary.

I certify that the information I provided is true and accurate to the best of my knowledge.

Signature of Applicant (or Parent/Guardian) **Date**

[ ] CHECK ALL SECTIONS ARE COMPLETED & A COPY OF THE EYEGLASS PRESCRIPTION IS ATTACHED.