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.