



PLEASE PRINT LEGIBLY USING BLUE OR BLACK INK. Incomplete or illegible applications cannot be processed.

Name of Applicant: _____ County of Residence: _____

Applicant's Address: _____

City: _____ Zip Code: _____

Applicant's Date of Birth: ____/____/____ Daytime Telephone Number: (____)_____

Applicant's Social Security Number: _____ - _____ - _____ (Must be provided if a Social Security Number has ever been issued to the applicant.)
If the applicant has never been issued a Social Security Number, please check here:

Number of people in the household (children and adults): _____ Total gross **yearly** household income*: \$ _____

***Total gross annual household income from all sources is calculated before deductions for taxes or any other allowances are taken. Sources of income include, but are not limited to: employment, severance, unemployment, child support, social security, SSI, disability, retirement, AFDC, worker's compensation and food stamps.**

Assistance needed with (check only one box): Eye Glasses only OR Eye Examination and Glasses (if prescribed)

Does the applicant have vision benefits under Medicaid, VA Health Care, TRICARE or any other policy? NO YES

Does the applicant have any other eye glasses benefits that can be accessed at this time? NO YES

Does the applicant have a current (less than 1 year old) prescription for eyeglasses? NO YES

Has the applicant failed a vision screening? NO YES

IMPORTANT: Final program approval and assignment is determined by Prevent Blindness North Carolina based upon specific eligibility criteria and available services. If an applicant is not approved or if services are not available the applicant will be notified as soon as possible. **Please allow 3 weeks for processing.**

I certify that all information provided on this application is true and factual to the best of my knowledge.

Signature of Applicant Date ____/____/____

MAIL A COPY of the completed application to: PBNC, 4011 WestChase Blvd, Ste 225, Raleigh, NC 27607
Applications must be mailed to this address and cannot be processed at any other location.
(Keep the original application for your records.)
OR SCAN to .pdf format and EMAIL the completed application to: eyecareforadults@pbnc.org
DO NOT FAX THE APPLICATION TO PBNC

For further information visit our website at nc.preventblindness.org or call 919-755-5044 or 800-543-7839.

For Office Use Only
Program: _____ Voucher No.: _____ Approval Date: _____ Denied: _____