KENTUCKY VISION PROJECT APPLICATION

The Kentucky Vision Project
PO Box 1422
Frankfort, KY 40602
Phone: 800-320-2406
Fax: 502-875-3782
kvp@kyeyes.org

PROOF OF HOUSEHOLD INCOME MUST BE SUBMITTED WITH APPLICATION (FAILURE TO DO SO WILL RESULT IN DELAY OF PROCESSING)

1. Today's Date_____

2. Name _____ **3. Date of Birth** _____

4. Street Address (Mailing Address) _____

5. City_____ **6. State**_____ **7. Zip**_____ **8. County** _____

9. Phone (___)_____-_____ **10. Email** _____

11. If there is no participating doctor in your county, you will travel to: (List Two Counties)

1._____ **2.** _____

12. Your last eye examination _____ **13. Name of Doctor**_____

14. Family Member Information: Include yourself and each person living in your household

Family Member Name	Relationship	Age	Covered by Medicare?	Medicaid?	
			☐	☐	
			☐	☐	
			☐	☐	
			☐	☐	
			☐	☐	

COMPLETE REVERSE SIDE

2018

IF THIS FORM IS INCOMPLETE, IT WILL NOT BE PROCESSED

15. Family Income Information: Applicant must include total income for each household member from any of these sources: 1) Job 2) AFDC 3) Unemployment 4) SSI 5) Disability 6) Workers Comp 7) Food Stamps 8) Bank Record 9) Letter stating no income (shelter letterhead)

***** MUST attach income source document(s) to process the KVP application*****

Family Member Name	Gross Income Per Month	Source of Income
GROSS Income Total	$	

16. List any source of health insurance your family has:

_____

17. Has anyone in your family been accepted for the Kentucky Vision Project before? YES ☐ NO ☐

If yes, whom? _____

THE KVP APPLICATION MUST BE COMPLETED BEFORE YOU SEE A DOCTOR. YOUR APPLICATION WILL BE SCREENED BY THE SALVATION ARMY, COMMUNITY ACTION CENTER OR KENTUCKY HOME PLACE COVERING YOUR AREA.

IF YOUR APPLICATION IS APPROVED:

1. **You will be notified by letter to set up appointment with an assigned KVP participating doctor.**
2. **Certain frames are available through KVP; if glasses are needed, you must select from these frames. Only plastic lenses are available through this program. Tinted lenses and no-line bifocals, or additional coatings are not available. Rimless, semi-rimless frames are not used with KVP.**
3. **KVP can only provide an individual with assistance one time.**
4. **At the time of the eye exam, a $25 donation to KVP is requested for the KVP applicant who needs glasses.**

I certify the above information is true, and I agree to abide by the guidelines of this program.

I authorize the professional office of my optometrist to release health information identifying me to the Kentucky Vision Plan (KVP) for the sole purposes of allowing me to participate in KVP and allow KVP to assess the effectiveness of the program. I understand it is completely my decision to authorize the release of this information to KVP, and I may revoke this authorization at any time. KVP will not release any health care information received about me to any person or entity not working for KVP. I fully understand this release and voluntarily agree to the disclosure of my health information to KVP as described herein.

Applicant's Signature_____**Date**_____

Screening Agent Use Only

Agent Signature

_____ **Date**

APPROVED ☐ **NOT APPROVED** ☐

If not approved please give reason_____