Directive to Administrators **(Specify which administrators)**	WAD **(Wednesday)** Publication Date	WAD Notice **Number**	No. of *Pages*
All Site Administrators	**November 18, 2009**		**1 of 16**

WAD Title **(Limit to 4-6 Words)**	Date Due **(if applicable)**	Not Applicable After
Resources for Eye Exams and Glasses		**June 4, 2010**

From	Title	Signature	Telephone
Meyla Ruwin **(Cabinet member or approved by one below)**	**Senior Executive Director, Student Support Services**		**242-2615**

Inform

(x) Certificated Staff (x) Classified Staff (x) Parents (x) Post on Bulletin Board Other As Needed

Administrative Directive

WHO: Students at SFUSD schools needing FREE resources for EYE EXAMS/GLASSES

WHAT: Poor vision in school age children can interfere with coordination, acquisition of skills, achieving developmental milestones, and the ability to learn properly. Early detection and correction of vision problems can alleviate some of these problems with less interference in the child's ability to learn.

WHERE: **The following organizations provide free and/or low cost vision care and glasses for SFUSD students who qualify**:

- Children's Vision First
- LensCrafters
- California Vision Project

HOW:

Eligibility

1) Students have either failed the school based vision screening or have demonstrated a need for vision care.
2) Family has economic need and no health insurance that covers eye exams and/or glasses.

OR

3) The family has economic need and has vision insurance but has lost/damaged their glasses and is unable to get new glasses under their current insurance plan.

To Apply

Instructions and applications attached. For information or questions, please contact:

Mary Main
Vision Screening Program
Student Support Services Department
242-2615

Approved	Cabinet Member	Title	Signature
	Trish Bascom	**Associate Superintendent, Student Support Services**	

Children's Vision First

(Formerly JVQ California)
1007 General Kennedy Ave. Suite 210
San Francisco, CA 94129
415.561.7793 *phone*
415.409.0587 *fax*

Principals

Students in your schools have an opportunity to participate in the new Children's Vision First vision program, which provides free eye exams and glasses for children who are in need and do not have health insurance.

The Children's Vision First program is designed to be simple and also flexible enough to empower the teachers and health care providers in your schools to identify children who are in need of help and are not being served through existing resources.

Children Who Are Eligible:

- Have failed school based vision screening (grades **K: 20/40,** grades **1-12: 20/30**).
- **Have no health insurance** that covers eye exams and glasses.
- Have no economic resources to provide for adequate vision care. (These students are usually eligible for, or are already participating in, the Free or Reduced Lunch Program.)

Making Referrals:

- Referrals can be made by any school employee who can verify the child's eligibility. This is usually the nurse, health clerk or teacher.
- Since not all grades are screened, teachers are especially vital in referring children from those grades not being screened.
- Teachers must make sure that any child suspected of having vision problems is brought to the attention of the school nurse or vision screener for testing.
- Each child failing the vision screening must then be qualified for eligibility for the Children's Vision First program.
- Qualification includes confirmation that the child has no vision insurance and is without economic means for adequate vision care.
- After a child has been qualified, a Children's Vision First Referral Form is filled out and faxed to Children's Vision First.
- Children's Vision First will assign the student to a doctor in his or her neighborhood and mail the doctor's information to the child's parent/guardian. A copy of this letter is faxed to the school contact that referred the child.
- The parent must call their assigned doctor to schedule the appointment.
- The child then receives a free eye exam, and if glasses are required, CVF will manufacture free, quality new glasses and send them to the doctor for dispensing.

Better vision is one of the easiest things we can do to improve a child's potential.
If you have any questions, please call Children's Vision First at 415.561.7793

*Keeping **CHILDREN** in focus*

Children's Vision First

(Formerly JVQ California)

1007 General Kennedy Ave. Suite 210
San Francisco, CA 94129
415.561.7793 *phone*
415.409.0587 *fax*

Attention: Teachers

Good News!!!

Students in your school have the opportunity to participate in the Children's Vision First program, which provides **free eye exams and glasses** for our most vulnerable children.

Children are eligible for the Children's Vision First free vision care program if they:

- Have failed the school based vision screening
- Have economic need and **no health insurance *of any kind that covers eye exams*** and glasses

Making Referrals:

- Make sure the child qualifies: **Has no health insurance and is in economic need**.
- Along with the standard school notification, every child who fails the school vision screening should be sent home with a Children's Vision First **"Free Eye Care"** letter. This letter is only a tool to help identify children who qualify for our program. **Teachers** should follow up and collect these letters and return them to the school nurse or health clerk. (Unless it is the teacher who will be filling out the Referral Forms)
- Verifying eligibility requirements with the parent/guardian **by phone is equally acceptable.**
- **Once a child is qualified a Children's Vision First Referral Form is filled out** and faxed to Children's Vision First: **415.409.0587** Nurses and vision screeners usually fill out and fax the Children's Vision First Referral Form, however, at some schools it is the teacher who fills out and faxes the Referral Form.
- **Any way you establish that a child is qualified is valid.** (Phone or collect info thru "Free Eye Care" sent home to parents)
- **The Referral Form is all we want or need.**
- **For all grades not being screened**, it is up to the teacher to make sure that any children suspected of having vision problems are brought to the attention of the vision screening team for testing.

What Happens Next?

- When the Referral Form is received by Children's Vision First, a doctor is assigned and a letter with instructions for contacting the doctor is mailed home to the child's parent/guardian.
- A copy of this letter will be faxed to the referrer for record keeping and follow up.
- The **parent must call** their assigned doctor to schedule the appointment for an exam.
- If eyeglasses are prescribed, Children's Vision First manufactures quality new glasses and sends them to the doctor for dispensing. **All doctor services and Children's Vision First eyeglasses are FREE OF CHARGE.**

Follow-up with parents/guardians in the process of verifying insurance and making and keeping doctor appointments **is extremely helpful.** ***Better vision is one of the easiest things we can do to improve a child's potential.***

Nurse/Vision Screener:_____ Phone:_____

For further information and/or to obtain the Referral Form, please contact **Mary Main at 415.242.2615**, or call Children's Vision First at 415.561.7793.

Keeping* CHILDREN *in focus

Children's Vision First

(Formerly JVQ California)
1007 General Kennedy Ave. Suite 210
San Francisco, CA 94129
415.561.7793 *phone*
415.409.0587 *fax*

Guidelines for School Nurses and Health Clerks

Children are eligible for the Children's Vision First free vision care program if they:

- Have failed the school based vision screening
- Have economic need and **no health insurance *of any kind that covers eye exams*** and glasses

Who can make a Referral?

- Any school employee who can verify the child's eligibility can make referrals to our program. Generally school teachers, health clerks, nurses and secretaries make referrals to Children's Vision First.

How do I make a Referral?

1) Make sure the child qualifies: <u>Has no health insurance and is in economic need</u>.

- Along with the standard school notification, every child who fails the school vision screening should be sent home with a Children's Vision First **"Free Eye Care"** letter. This letter is only a tool to help identify children who qualify for our program. **Teachers** should follow up and collect these letters and return them to the school nurse or health clerk.
- Verifying eligibility requirements with the parent/guardian **<u>by phone is equally acceptable</u>.**
- **Any way you establish that a child is qualified is valid.** (phone or collect info thru "Free Eye Care" sent home to parents) **<u>Once a child is qualified just fill out a Referral Form</u>. <u>The Referral Form is all we want or need</u>.**

2) For all children who qualify, fill out a Children's Vision First Form. You only need to fill in the left side of the form with the child's information and your contact information. (It is extremely important to print very clearly)

3) Fax the completed Children's Vision First Referral Form to **415.409.0587**.

What Happens Next?

- When the Referral Form is received by Children's Vision First, a doctor is assigned and a letter with instructions for contacting the doctor is mailed home to the child's parent/guardian.
- A copy of this letter will be faxed to you for record keeping and follow up.
- The **<u>parent must call</u>** their assigned doctor to schedule the appointment for an exam.
- If eyeglasses are prescribed, Children's Vision First manufactures quality new glasses and sends them to the doctor for dispensing. **All doctor services and Children's Vision First eyeglasses are <u>FREE OF CHARGE.</u>**

Important Reminders:

- Each CVF **Referral Form must be filled out and signed by school personnel**.
- Only refer eligible children. Doctors are ***donating*** their time. Therefore, you must refer ***only*** those students who truly qualify. Only ***one*** exam per calendar year is allowed.

Replacing Broken or Lost Eyeglasses:

- A second pair or a replacement pair for lost or broken glasses may be purchased for $35.00.

For further information and/or to obtain the Referral Form, please contact **<u>Mary Main</u> at <u>415.242.2615</u>,** or call Children's Vision First at 415.561.7793.

Keeping* CHILDREN *in focus

Children's Vision First

(Formerly JVQ California)

1007 General Kennedy Ave. Suite 210
San Francisco, CA 94129

FREE VISION CARE

Dear Parent/Guardian,

The vision screening performed at your child's school has determined that your child needs further eye care.

If you have **NO MEDICAL INSURANCE** and are in extreme **ECONOMIC NEED,** you may qualify for the Children's Vision First vision program.

If you have MediCal, Kaiser, PacifiCare, Healthy Families or any other medical insurance, please get immediate help for your child through your own medical insurance. Your school nurse may be able to assist you if necessary. The inability to see clearly puts school age children at a disadvantage that may follow them for a life time and is easily correctable.

Please fill out this form and check all that apply from the questions below, then **RETURN THIS LETTER TO YOUR SCHOOL** to help us establish if your child qualifies. Just checking a box does not result in being qualified. **IF your child qualifies**, you will receive a letter from Children's Vision First within 2 weeks assigning you to a doctor in your neighborhood and asking you to **call to set up an appointment right away** to receive a free eye exam and glasses.

Child's Name: _____ **Date of Birth:**_____
First Middle Last

Grade: _____ **Name of School:** _____

Parent/Guardian Name: _____

Phone: _____ **Phone 2:** _____

Address: _____
Street Address / Mailing Address City State Zip

Language Spoken in Home: _____

Please ☒ check ***all*** that apply:

- ☐ **NO MEDICAL INSURANCE**
- ☐ **EMERGENCY MediCal** ONLY
- ☐ My child is, or has been eligible for the Free and Reduced Lunch Program
- ☐ If we qualify, **we can get to** UC Berkeley School of Optometry to receive our services

Parent/Guardian Signature: _____

School Nurse/Vision Screener: _____Phone: _____
(Or Alternate School Contact)

*****Teachers, Nurses, and Secretaries:*** This letter is a tool to **help you qualify children** for the Children's Vision First program. Qualification can also be established by phone with the parent/guardian. **IF** a child qualifies, school personnel must fill out and fax a **Children's Vision First Referral Form.** Please contact **Mary Main at SFUSD Vision Screening Program 415.242-2615 for further information or to obtain the Children's Vision First Referral Form.**

Children's Vision First

(Anteriormente JVQ California)

1007 General Kennedy Ave. Suite 210
San Francisco, CA 94129

SERVICIOS GRATIS DE OPTOMETRIA

Estimados Padres/Guardianes:

La selección de la visión realizada en su escuela ha determinado que su niño necesita el cuidado adicional de ojo.

Si usted no tiene **SEGURO MEDICO** y está en **NECESIDAD ECONOMICA** extrema, usted puede calificar para el Programa de la Visión de Children's Vision First.

Si usted tiene Médico, el Káiser, PacifiCare, o cualquier otro seguro médico, obtiene ayuda inmediata para su niño por su propio seguro médico. Su enfermero de la escuela puede ser capaz de ayudarlo si es necesario. La incapacidad para ver pone claramente en la escuela niños de edad en situación desventajosa que los pueden seguir para un tiempo de vida y son fácilmente corregidos.

Llene por favor esta forma y chequee todo que aplica de las preguntas abajo, entonces **VUELVE ESTA CARTA A SU ESCUELA** para ayudarnos establecer si su niño califica. **SI su niño califica**, usted recibirá una carta de Children's Vision First dentro de 2 semanas que asignan usted a un doctor en su vencimiento y poderlo llamar para establecer una cita para recibir un examen libre de ojo y lentes.

Nombre de hijo/a: _____ **Fecha de Nacimiento:**_____
Primer Segundo Nombre Apellido

Grado:_____ **Nombre de escuela:** _____

Padre/Guardian Nombre: _____

Teléfono: _____ **Teléfono 2:** _____

Direccion: _____
Dirección de Calle/ Direccion Postal Ciudad Estado Codigo Postal

Language Hablado en Casa: _____

Favor ☒ marque a ***todo*** lo que apliqué:

- ☐ **NO TIENE SEGURO QUE CUBRE**
- ☐ **SOLO TIENE MediCal EMERGENCIA**
- ☐ Está o ha sido elegible para el programa gratis de almuerzo
- ☐ Si Qualifica, puede llegar a la Escuela de Optometria en la **Universidad de Berkeley** para recibir cuidado de los ojos

Firma de Padre/Guardian: _____

Enfermera de la Escuela:_____**Teléfono:**_____
(O Alternado Contacto de la Escuela)

*****Teachers, Nurses, and Secretaries:*** This letter is a tool to **help you qualify children** for the Children's Vision First program. Qualification can also be established by phone with the parent/guardian. **IF** a child qualifies, school personnel must fill out and fax a **Children's Vision First Referral Form.** Please contact **Mary Main at SFUSD Vision Screening Program 415.242-2615 for further information or to obtain the Children's Vision First Referral Form.**

JVQ CA
Jeppesen VisionQuest California
1007 General Kennedy Ave. Suite 210
San Francisco, CA 94129
www.jvqca.org

免費眼睛護理服務

親愛的家長/監護人：

在您子女學校進行的視力檢查確定，您子女需接受進一步的眼睛護理。

若您**沒有醫療保險**，並且**經濟**非常困難，那麼您便合乎資格，可參加 JVQ 加州眼睛護理計劃。

若果您有 MediCal、 Kaiser、 PacifiCare 或任何其他醫療保險，請馬上通過自己的保險，去尋求幫助。需要時，您子女學校的護士可提供幫助。學齡兒童若看東西不清楚，會對自己不利，一生受影響，但其實這情況很容易糾正過來。

請填妥以下表格，在相應的地方畫 X，然後**將本信交還您子女學校**，以便我們確定您子女的資格。請注意：單單在格子上畫 X 並不表示您子女合資格。**若您子女合乎資格，**您將在兩星期內收到 JVQCA 的信函，通知您打電話到您住區內所指定的醫生，預約時間，接受免費檢查及眼鏡。

子女姓名： _____ 出生日期：_____
名 中間名 姓

年級： _____ **校名：** _____

家長/監護人姓名： _____

電話： _____ **電話 2：** _____

地址： _____
門牌地址 / 郵址 城市 州 郵區編號

在家所說語言： _____

請在***所有***適用空格上畫 X（例子：☒）：

☐ **沒有醫療保險**
☐ 只有 **EMERGENCY MediCal** 保險
☐ 本人子女現在或曾經合乎免費及減費午餐計劃的資格
☐ 若我們合資格，**我們可以到**柏克萊加大視光學院接受服務

家長/監護人簽名：_____

學校護士/驗眼師： _____ **電話：** _____
(或另外的學校聯絡)

教師、護士及秘書請注意：本信旨在**幫助各位定出**符合 JVQCA 計劃**資格的學生**。資格的確定也可通過打電話與家長/監護人聯絡而進行。**若**孩子符合資格，學校人員必須填妥及傳真一份 **JVQCA 轉介表格**。如欲查詢詳情及/或索取 JVQCA 轉介表格，請聯絡三藩市聯合校區視力檢查計劃之 Mary Main，電話：415.242-2615，內線 3205。

Ph: (415) 561.7793
Fax: (415) 409.0587

CHILDREN'S VISION FIRST

Referral Form

1007 General Kennedy Ave. Suite 210
San Francisco, CA 94129

Section I: to be filled out COMPLETELY by school personnel (PLEASE PRINT):

Date:_____ County:_____

School District:_____

Student Name:_____
First MI Last

Date of Birth:_____ Sex:_____

Grade:_____ Teacher:_____

Parent/Guardian: _____

Mailing Address: _____

Physical Address: _____

City: _____ State: _____ Zip: _____

Home Phone: (_____)_____-_____ Other:(_____)_____-_____

Child can get to UC Berkeley School of Optometry ☐ Yes ☐ No

☐No Insurance ☐Emergency MediCal Only ☐Other Ins._____

☐ **DISPENSE ONLY** Insurance Covers Exam but not Glasses

Language spoken in the home:

☐ English ☐ Spanish ☐ Cantonese
☐ Mandarin ☐ Vietnamese ☐ Portuguese

Does child wear glasses now? ☐ Yes ☐ No

Visual Acuity
R:_____
L:_____

Screening
Info:

School Name:_____ ES MS HS

Contact:_____

Phone: (_____)_____-_____, ext._____

Fax: (_____)_____-_____

Eligibility has been Verified by:

Signed: _____
Screener/School Personnel

Section 2: to be filled out by Children's Vision First Doctor (PLEASE PRINT):

Student Name: _____

Dr. _____ County:_____

Dr. Address _____

Dr. Phone: ( ) - Dr. Fax: ( ) -

☐ DISPENSE ONLY - NO EXAM PERSCRIPTION PROVIDED**

Diagnosis (circle all that apply) **Exam date:** _____

Amblyopia Esotropia Hyperopia
Astigmatism Emmetropia Myopia
Color Blind Glaucoma Strabismus
Other:_____

☐ Ordering 2nd Pair $35.00

☐ Ordering Frame Only $12.50*

To Order 2nd Pair: Doctor Mails **2nd Referral Form with Check to Children's Vision First**

	Sphere	Cyl	Axis	Prism	Direction	Base Curve	Lens type
R							SV
L							FT
	Add	Seg Ht	OC Ht	**PD**			TRI
R				DISTANCE			OTHER
L				NEAR			

FRAME	COLOR	Eye Size	DBL	VQ SUPPLY	
				ENCLOSED	

SPECIAL INSTRUCTIONS:

Send To:

CVF Office Use Only:
Date received _____
Faxed to Dr: _____

Dr. Info: Parent_____School_____
Faxed to Lab: _____Dispensed_____

Children's Vision First: **Formerly JVQ California**

*** $12.50 replacement charge does not apply within warranty.**
** Patient MUST bring current perscription

Revised 2/08

LensCrafters/EyeExam of California

LensCrafters/EyeExam of California has several community assistance programs and has been extremely generous with the students of SFUSD.

HOMETOWN DAY As part of the Gift of Site sponsored Hometown Day's yearly campaign; LensCrafters will be donating free eye exams and prescription glasses to SFUSD students in need of new glasses. This event is for one day only.

When December 1st, 2009. Eye exams and dispensing of glasses occurs on this day only. In some situations, students may need to return to LensCrafters to pick up their glasses at a later date.

Eligibility

- Students have either failed the school based vision screening or have demonstrated a need for vision care.
- Family has economic need and no health insurance that covers eye exams and/or glasses, or
- Family has economic need and has vision insurance but has lost/damaged their glasses and is unable to get new glasses under their current insurance plan.

Procedure

- Contact the Hometown Day Coordinator at one of the LensCrafters/EyeExam of California stores listed below, request an appointment.
- Complete student referral form (complete with school tax ID number) and fax to LensCrafters.
- A patient information form (complete with parent/guardian signature) needs to be completed for all students who will be participating in Hometown Day without their parent/guardian. This form must be with the student at the time of their exam.

Participating Stores

LENSCRAFTERS, MARKET STREET
685 MARKET STREET
SAN FRANCISCO, CA 94105
Ph: (415) 896-0680 Fax: (415) 896-0352

LENSCRAFTERS, PINE & BATTERY
100 BATTERY STREET
SAN FRANCISCO, CA 94111
(415) 399-1473 Fax: (415) 399-1960

LENSCRAFTERS, STONESTOWN GALLERIA
3251 20TH AVENUE SPACE 219
SAN FRANCISCO, CA 94132
(415) 566-9199

LENSCRAFTERS, 280 METRO CENTER
53 COLMA BLVD #F2
COLMA, CA 94014
(650) 992-2700 Fax (650) 992-3215

GIFT OF SITE PROGRAM

Each of the LensCrafters/EyeExam of California stores donates 2-3 free eye exams and eyeglasses per month for students in need of eye exams and new glasses. This program is on-going through out the year.

When Most stores set aside one day per week for Gift of Site appointments. Stores should be contacted directly for schedule

Eligibility

- Students have either failed the school based vision screening or have demonstrated a need for vision care.
- Family has economic need and no health insurance that covers eye exams and/or glasses, or
- Family has economic need and has vision insurance but has lost/damaged their glasses and is unable to get new glasses under their current insurance plan.

Procedure

- Contact the Gift of Site Coordinator at one of the LensCrafters/EyeExam of California stores listed below, request an appointment.
- Complete student referral form (complete with school tax ID number) and fax to LensCrafters.
- Parent or Guardian of student needs to contact store directly to confirm appointment.

Participating Stores

LENSCRAFTERS, MARKET STREET
685 MARKET STREET
SAN FRANCISCO, CA 94105
Ph: (415) 896-0680 Fax: (415) 896-0352

LENSCRAFTERS, STONESTOWN GALLERIA
3251 20TH AVENUE SPACE 219
SAN FRANCISCO, CA 94132
(415) 566-9199

LENSCRAFTERS, PINE & BATTERY
100 BATTERY STREET
SAN FRANCISCO, CA 94111
(415) 399-1473 Fax: (415) 399-1960

LENSCRAFTERS, 280 METRO CENTER
53 COLMA BLVD #F2
COLMA, CA 94014
(650) 992-2700 Fax (650) 992-3215

LENSCRAFTERS, SERRAMONTE CENTER
5 SERRAMONTE CENTER
DALY CITY, CA 94015
(650) 992-1615 Fax (650) 992-1617

LENSCRAFTERS, THE SHOPS AT TANFORAN
1150 EL CAMINO REAL #265
SAN BRUNO, CA 94066
(650) 583-8693 Fax (650) 583-2097

San Francisco Unified School District
Student Support Services Department
1515 Quintara St.
San Francisco, CA 94116
415/242.2615
Fax: 242.2618
Http://www.healthiersf.org

Lenscrafters/EyeExam of California
Attn: Gift of Site Coordinator
Fax: _____

Dear Gift of Site Coordinator:

I would like to introduce and refer a student to your Gift of Site Program. I believe that he/she could greatly benefit from the services that LensCrafters/EyeExam of California has generously offered to the students of San Francisco Unified School District. Unfortunately, some of our students are not insured for vision coverage and the need for eye examinations and glasses is so important for their success in learning. Your service is very much appreciated.

Below you will find pertinent information regarding the student I am referring. Please let me know if you need further information. Thank you on behalf of the children and families of San Francisco.

_____
Name/Title of Referring Staff Member

_____
School Site

_____ / _____
Phone Number *Fax Number*

_____
Date of Referral

Students Name _____ Date of Birth _____

Home Address _____

Parent/Guardian Name _____Phone_____

Language Spoken at Home _____

School _____ School Tax ID _____

OF CALIFORNIA

A LICENSED VISION HEALTH CARE SERVICE PLAN

PATIENT INFORMATION - Please Complete at Each Annual Examination (Please Print)

☐ Mr. ☐ Master ☐ Mrs. ☐ Dr. ☐ Ms. | Last Name | First Name | Initial | Sex ☐ Male ☐ Female | Birthdate | Age

Home Address | City | State | Zip

Preferred Telephone Number ( ) _____ Home Work Cell (circle option) Secondary Telephone Number ( ) _____ Home Work Cell (circle option)

We use phone calls to remind patients of their appointments. We will use the phone number you provide and the call may be live or prerecorded.

Language Preference: English ☐ Spanish ☐ Chinese ☐ Vietnamese ☐ Other _____

Do you need assistance from an interpreter? ☐ Yes ☐ No

Race: ☐ White ☐ African American ☐ Hispanic ☐ Asian/Pacific Islander ☐ Other _____

Employer Name | Employer Address | City | State

Your Occupation | Referred By

Will you be using any vision benefits or programs? ☐ No ☐ Yes If yes, please fill in the information below.

Vision Plan Name | Member ID # | Insured's Name | Patient's Relationship to Insured

Would you like to be billed for your services today through the *LENSCRAFTERS* account? ☐ Yes ☐ No

*** Note to Technician:** *If yes, please fill out LENSCRAFTERS account application.*

We will file an insurance claim for any plan under which we are providers. If you have a question about which plans for which we are providers, please ask the receptionist. Payment is expected at time of treatment.

Are you interested in looking at eyeglasses at LensCrafters today? _____

1. Do you have? (please check all that apply)
   ☐ eyestrain ☐ pain ☐ double vision
   ☐ dry eyes ☐ itchy eyes ☐ blurred vision with glasses or contacts
   ☐ floaters ☐ flashes of light ☐ severe or frequent headaches
   ☐ frequent neck and shoulder pain
2. Name of your primary physician: _____ Date of last physical: _____ HMO Member? ☐ No ☐ Yes
3. Age of present glasses: _____ Date of last eye exam: _____
4. Have you been examined at EYEXAM of California before? ☐ No ☐ Yes Which Office: _____
5. Have your eyes been dilated before? ☐ No ☐ Yes When: _____
6. Have you had retinal photographs taken before? ☐ No ☐ Yes When: _____
7. Do you or any blood relatives (grandparents, parents, brothers, sisters, children) have? (please check all that apply)

	Self	Blood Relative		Self	Blood Relative
retinal disease	☐	☐	high blood pressure	☐	☐
cataracts	☐	☐	thyroid problems	☐	☐
glaucoma	☐	☐	asthma	☐	☐
diabetes	☐	☐	lung disease	☐	☐
high cholesterol	☐	☐	heart disease	☐	☐

8. Are you pregnant? (if applicable) ☐ No ☐ Yes
9. Are you being treated for any medical condition? ☐ No ☐ Yes Please List _____
10. Are you taking any medications? ☐ No ☐ Yes Please List _____
11. Are you allergic to any medication including eye drops? ☐ No ☐ Yes Please List _____
12. Do you have or have you ever had any eye disease, injury or surgery? ☐ No ☐ Yes
    If yes please explain: _____

PATIENT VERIFICATION

The patient history information that I have provided above is accurate and complete to the best of my knowledge.	Signature (If under 18 years of age, parent signature required)	Date

california vision foundation

Patients

Information for Patients

Apply Here

Qualifications:
Individuals must meet the following criteria to qualify for a free eye exam and low cost glasses:

1. There must be at least one adult in the household that is employed at least part-time.
2. The household must qualify as low income.
3. The individual applying for the exam may not have had an exam in the past two (2) years.
4. The individual applying for the exam may not have vision insurance.

How to Apply:
Applications are available on this website (click here for application)
or call 1-800-877-5738 and request one by mail or fax.

What to Expect:
Once an individual has qualified for the program, every attempt will be made to match them with a volunteer optometrist in their area. Optometrists are donating their services and are, therefore, limited in some areas. Waiting times depend on the number of available appointments and the amount of qualified applicants in any particular area. An average waiting period is 2 to 3 months, but can vary from city to city.

All applicants that have been matched to an optometrist will receive a letter in the mail containing the name, address and telephone number of the optometrist that they can call to schedule an appointment. Appointments will not be scheduled for patients who fail to contact the optometrist's office within 60 days of receiving notification of eligibility.

Every attempt is made to assign members of the same family or household to the same doctor, but individuals will be sent to different doctors if it allows them to be seen in a shorter time frame. While an entire family or household may use just one application to apply for the program, all individuals who qualify for the program will receive their own letter detailing the doctor they have been assigned to.

Qualified patients will receive a free comprehensive eye exam. If glasses are needed, they will be provided for a fee of $20.

We will be constantly updating this website,
so **bookmark us** today and check back often!

California Optometric Association • 2415 K Street, Sacramento, CA 95816
(800) 877-5738 • contact@coavision.org• http://www.coavision.org/

CALIFORNIA VISION PROJECT (CVP) APPLICATION FORM

The California Vision Project provides free eye exams to eligible low-income working families.
Services are donated by volunteer optometrists throughout California.

Eligibility requirements: (PLEASE READ)

- At least one adult in the household must be employed (full-time or part-time);
- The person(s) seeking an eye exam must have no public or private insurance that covers eye exams;
- Applicants must not have had an eye exam in the last 2 years; and
- Applicants are low-income and are unable to pay for eye care.

Please answer all questions below. Verification may be requested.

1. Is anyone in your household currently employed (full-time or part-time)? ☐ Yes ☐ No
2. What is the total number of people in your household living with you, including yourself? _____
3. What was your household's approximate gross annual income before taxes and deductions? _____
4. How far are you able to travel for your appointment? _____ miles
   Please list any particular cities that you would be able to travel to for your appointment:
   _____

List family members who are applying for a free eye exam:

Name	Date of Birth	Has this person had an eye exam in the last two years?	Does this person have any private of government insurance that covers eye exams?
1.	/ /	☐ Yes ☐ No	☐ Yes ☐ No
2.	/ /	☐ Yes ☐ No	☐ Yes ☐ No
3.	/ /	☐ Yes ☐ No	☐ Yes ☐ No
4.	/ /	☐ Yes ☐ No	☐ Yes ☐ No

Home address: (Please print)

Address_____

_____ Apt. #_____

City _____

State _____ Zip _____

Daytime telephone number ( ) _____-_____

Employer address: (Please print)

Address_____

_____

City _____

State _____ Zip _____

Work telephone number ( ) _____-_____

Your completed form will be reviewed to determine your eligibility. Eligible patients will be notified by mail and will receive a complete eye exam without cost if a volunteer is available in your area. If eyeglasses are needed, a $20 administrative fee will be charged for each prescription.

Mail this completed application to:
California Vision Foundation
2415 K Street, Sacramento, CA 95816
or Fax to (916) 448-1423

If you have any questions please contact Cynthia Robbins or Michelle Whitlow at (800) 877-5738.

Procedure for Replacement of Lost or Damaged Glasses for SFUSD Students