REQUEST FOR

YOUTH LOW VISION SERVICE

Eligibility:

- Services are available to children beginning at birth until age 14.
- Visual acuity of 20/70 or less in the best corrected eye
- Visual field restriction 40 degrees or less in the best eye with documented deteriorating eye diagnosis

☐ **Request for service:** An eye report or letter from an Optometrist or an Ophthalmologist, dated no more than 2 years from application date, must be included with this request if this is the first time Youth Low Vision Services are being requested on behalf of an identified student.

☐ **Referral for Bi-Annual Evaluation**

☐ **Other (in the case of significant vision loss, or lost or damaged devices): _____**

Financial Needs Assessment: A sliding scale, according to family size from 2 to 8 family members, will be used to determine financial participation. Please refer to https://aspe.hhs.gov/2019-poverty-guidelines for specific income thresholds.

Income Verification documentation - Please check one:

☐ Poverty Level = $16,910 for a 2-person family. Add $4,420 for each additional person in family to get the poverty threshold.

☐ $1 to $10,000 above poverty threshold for family size - $10

☐ $10,001 to $20,000 above poverty threshold for family size - $20

☐ $20,001 to $30,000 above poverty threshold for family size - $30

☐ $30,001 to $50,000 above poverty threshold for family size - $50

☐ > $50,001 above poverty threshold for family size - $100

By checking one the above boxes BSBP is accepting this information to be considered when providing funding for youth low-vision services.

Student's name:_____
(Please Print)

Date of birth: _____

Address: _____

City, state, and zip code: _____

Telephone number, including area code: _____

Race: _____ Gender: _____

Vision/Medical Insurance: _____

Low Vision Provider: _____

Teacher Consultant: _____Telephone: _____

School District: _____

Parent/guardian signature

I am applying for Youth Low Vision services available from the Bureau of Services for Blind Persons (BSBP) on behalf of the minor child identified above. In signing this referral form, I also authorize BSBP staff to share information with the referring school district and low vision practitioner as necessary to provide optimal services.

Signature: _____ Date: _____

Print name: _____

Contact Number: _____

Email: _____