



REQUEST FOR YOUTH

LOW VISION SERVICE

Eligibility:

- Services are available to children beginning at birth – up to 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 base upon your family size and income will be used to determine financial participation towards your student's low vision exam and devices. Financial participation amount will be paid twice directly to the low vision provider. The first payment will be made at the time of the low vision exam and the second payment will be made when the low vision devices are ordered.

Household size:

Household income:

Please refer to

<https://aspe.hhs.gov/poverty-guidelines> for specific income thresholds.

Income Verification - Please check one:

- Poverty Level = for a 2-person family - \$0
- \$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 of the above boxes BSBP is accepting this information to be considered when providing funding for youth low-vision devices and 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. I also agree to pay the identified financial participation amount noted above.

Signature: _____ **Date:** _____

Print name: _____

Contact Number: _____

Email: _____