PARENTAL CONSENT
FOR ELIGIBILTY ASSESSMENT

Highpoint Health has developed a multi-professional solution to help address the substantial number of visually impaired school aged students (5 to 18 years) in our service area (Dearborn, Ohio, Switzerland, and Ripley Counties). The Highpoint Health sponsored program, Vision Possible, includes local optometrists and our local school corporations, and the generous support of the Essilor Vision Foundation, the Prevention of Blindness-Ohio and the United Way.

A written consent is required to authorize a Highpoint Health State Navigator to contact you to determine eligibility for one of the three vision benefit programs that your child may be eligible for. Eligibility requirement questions include household size, income, insurance, etc. If your child is found to be eligible, a program consent will be sent to you as a follow-up regarding a school bus field trip to a local optometrist for an eye evaluation and glasses. There is no cost for either the eligibility determination or the eye evaluation program.

PARENT/GUARDIAN CONSENT, AKNOWLEDGEMENT AND RELEASE OF INFORMATION

A. I, the undersigned parent/guardian of student, hereby gives consent to be contacted by a Highpoint Health State Navigator to conduct a Vision Eligibility Assessment which includes both medical and financial information.
B. I, the undersigned parent/guardian of student, allow student's school to share Vision/Medical information as contained in the student's school record to assist making eligibility determinations.
C. Please check all the appropriate boxes that apply and give a brief explanation. The Student:
    - ☐ Has difficulty getting to an eye doctor
    - ☐ Has had glasses in the past but does not now
    - ☐ Has not been seen by an eye doctor or optometrist in the last year

Comments:

_____

_____

_____

I have read this carefully and know it contains a release provision

Name of Student: _____

Parent/Guardian Signature: _____

Printed: _____

Relationship: _____

Date: _____

ELIGIBILITY FORM

Student Information

First Name: _____ **MI**:_____

Last Name:_____

Date of Birth: (mm/dd/yyyy):_____ **Gender**: M / F

Social Security Number: (no dashes):_____

*NOTE: This is a Highpoint Health program requirement. In order for the application to be processed, you must enter a **valid** social security number.*

Street Address:_____

Please indicate if this address is a "street"; "lane"; "road"; "avenue"; "circle"; "court", etc.

City:_____ **State**:_____ **Zip Code**:_____

County:_____

School Attending:_____ **Grade**:_____

Insurance Information for Student

Please Mark the Coverage that Applies to the Student:

☐ **Medicaid**
For example:
Cooperative Manage Care Services Anthem
(Hoosier Healthwise, Healthy Indiana Plan, Hoosier Care Connect)
Caresource
(Hoosier Healthwise, Healthy Indiana Plan)
MDwise
(Hoosier Healthwise, Healthy Indiana Plan)
MHS
(Hoosier Healthwise, Healthy Indiana Plan, Hoosier Care Connect)

☐ **Medicare Part A**

☐ **Medicare Part B**

☐ **Medicare with a Supplement**

☐ **Private Insurance w/Vision Benefits**

☐ **Private Insurance w/o Vision Benefits**

☐ **Affordable Care Act, i.e. Market Place**

☐ **None**

Insurance Card Information: *(Please provide a copy of card)*

Insurance Company Name: _____

Policy Holder Name: _____ Policy Holder DOB: _____

Policy Number: _____

Income Information for Family

Total Family Annual Gross Income: $_____ Family Size:_____

☐ ***Parent/Guardian Verifies that the information contained in this application is complete and accurate***

Parent/Gaurdian Name: _____

Telephone Number (with Area Code): _____

For Office Use Only

Income Meets Criteria? ☐ Yes ☐ No

Assistance/Insurance Benefits Comments:

_____

_____

_____

If you have indicated that the student has insurance benefits, please explain why the student is not using their benefits to get an eye exam and/or eye glasses

Partner Agency Advocate Comments:

_____

_____

_____

_____

☐ ***Partner Agency Verifies that the information contained in this application is complete and accurate***

_____ _____

Name (*Highpoint Health Employee Determining Eligibility)* **Date**

HIGHPOINT HEALTH