FLORIDA HEIKEN
Children's Vision Program, LLC

Apply for FREE Eye Exam and Glasses

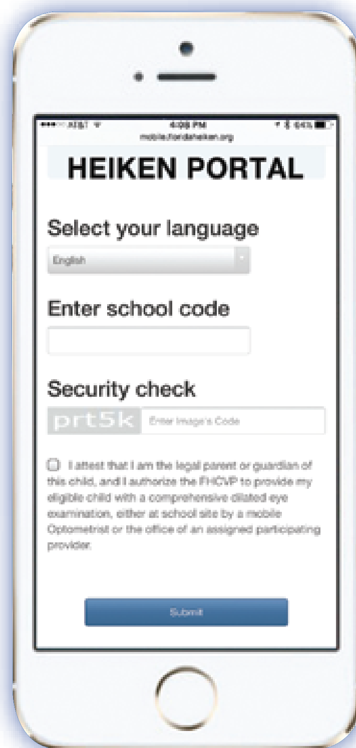
ON OUR NEW HEIKEN PORTAL: WWW.FLORIDAHEIKEN.ORG

Accessible on any internet enabled smart phone/tablet/computer

English / Español / Kreyòl

Why Use the Heiken Portal?

- Easy to Use
- Quicker with Autofill
- Confidential and Secure
- More Accurate
- Faster Processing



What's Needed to Apply

- School Provides (see over)
- School Code
- Referral Code (if not school)
- Failed Screening Date
- Student ID

It's as Easy as 1...2...3...

1. Obtain info from school nurse/ counselor
2. Visit www.floridaheiken.org
3. Click on Heiken Portal to apply

Parents Are Welcome to Apply for Any Florida Public School Student PreK-12

Heiken Portal was made possible by the generous support of

601 SW 8th Avenue • Miami, Florida 33130
(305)856-9830 or 1(888)996-9847
www.floridaheiken.org

2017-2018 Free Eye Exam & Eyeglasses School Program

FOR FASTER, SECURE PROCESSING, APPLY ON YOUR PHONE AT: WWW.FLORIDAHEIKEN.ORG

HEIKEN PORTAL INFO **(For School Personnel Use Only):**	**For Heiken Use Only:** Scanned ☐
County: ________________________ School Code: _______________	Account #.:_______________
Vision Screening Fail Date (Mandatory): __________________________________	Eligibility Status: ___________
Referring school or agency: ____	Date Eligibility Verified: ____________
Referral Agency Code (if referral is not from school): ________________________	Insurance: _________________
	Subscriber ID:

YES ☐ **NO** ☐ I allow my child to be photographed by FHCVP for public relations purposes, and waive any/all present/future claims to the photos.

School (full name) ___________________________________ **Grade** ___ **Teacher** ___________ **Student I.D.** __________________

Student's Name ____ **Male/Female Student's Date of Birth** __________________

Address______________________________________ **Apt** _____ **City** ______________________ **Zip Code** ____________________

Cell Phone____ **Parent's Day Phone** _______________________________________

Parent/Guardian Name (print) ____________________________________ **Email Address** _________________________________

Ethnicity (Circle One): African-American Asian Hispanic Native-American White (non-Hispanic) Haitian Other

Spoken Language (Circle One): English Spanish Creole Portuguese Other ___________________________________

Has your child seen an eye doctor in the past year? Yes ________ No________ Does your child wear glasses? Yes____ No _____

Please list any medication or eye drops your child uses: ____

Please list any allergies your child has:____

Does your child have any special needs/development delays? Yes ________ No ________Explain__________________________

Does your child require any auxiliary aids (such as interpreter, sign language, visual aids, wheelchair, Braille?) Yes_____ No_______

If "Yes", please explain: ____

Has your **child** had any of the following:

YES	NO	
☐	☐	Eye Surgery / Injury or Condition
☐	☐	Vision Therapy
☐	☐	Headaches
☐	☐	Glaucoma
☐	☐	Diabetes
☐	☐	Sickle Cell
☐	☐	Asthma

Has your child's **family** had any of the following:

YES	NO	
☐	☐	Eye Turn / Lazy Eye
☐	☐	Blindness
☐	☐	Macular Degeneration
☐	☐	Glaucoma
☐	☐	High Blood Pressure
☐	☐	Sickle Cell
☐	☐	Other

Please explain any "YES" answers from above: ____

Consent for eye examinations - By signing below, I authorize the FHCVP to provide my eligible child with a comprehensive dilated eye examination, either at school site by a mobile Optometrist or the office of an assigned participating provider.

Notice of privacy practices – By signing below, I understand that the Notice of Privacy Practices for the FHCVP is available for review if I should request a copy via phone at (305)856-9830 / 1(888)996-9847, and that security cameras are in use and recording on all mobile units at all times.

Mutual exchange of information – By signing below, I authorize the mutual release of information among the FHCVP, its funders, my County Public Schools (CPS), and participating providers of any and all optometry medical reports on my child, to determine appropriate care. I also authorize my CPS to release any required information that may be missing or unclear to process this application. I understand that I may be contacted by FHCVP or its funders to provide an anonymous opinion about the services received, but I have the right to refuse to participate if contacted.

*I/We release and hold harmless the County School Board of any and all responsibility and liability for any injury or claim resulting from participation in the FHCVP because of accident or mishap involving the participation of my child/ward in the program.

LEGAL GUARDIAN SIGNATURE (to receive exam) ____ **Date:** ____________

Authorization to use insurance benefits —If my child has an insurance plan that is accepted and has an opportunity to be seen on a mobile unit visit (only), I hereby authorize Florida Heiken Children's Vision Program to use my child's insurance for a comprehensive, dilated eye exam, and eyeglasses, if prescribed (includes selected frames, clear poly lenses, and no add-ons). I understand this will use my child's insurance vision benefit.

SIGNATURE (Authorization to use insurance benefits) _______________________________________ **Date:** ___________

The Florida Heiken Children's Vision Program is an equal opportunity organization and does not discriminate against otherwise qualified applicants on the basis of race, color, religion, ancestry, age, sex, marital status, national origin, disability or veteran status. Revised 8.16.2017

PARENTS: Apply for this **FREE** service with faster processing from your mobile phone at: **WWW.FLORIDAHEIKEN.ORG**. If you don't have internet access, complete, sign, and return this to your child's school. For any questions, please call 1-888-996-9847.

School/Agency: Please fax completed form with Heiken Fax Cover Sheet to (305)856-9840 / 1(888)980-8474