VFW DEPARTMENT OF CALIFORNIA

META SMART GLASSES ELIGIBILITY FORM

For Veterans, Veteran Spouses, and Veteran Dependents with Visual Impairment

Applicant Name: _____ Date: _____

Mailing Address: _____

Phone: _____ Email: _____

Eligibility Category

☐ Veteran ☐ Spouse of a Veteran ☐ Dependent of a Veteran

Veteran's Name (if spouse/dependent): _____

Visual Impairment Screening

Diagnosed visual impairment? ☐ Yes ☐ No

Conditions:

☐ Macular Degeneration ☐ Glaucoma

☐ Diabetic Retinopathy ☐ Ocular Injury

☐ Brain Injury Affecting Vision ☐ Stroke Affecting Vision

Does vision loss affect daily activities? ☐ Yes ☐ No

Describe impact: _____

Visual Eligibility Criteria

☐ Best-corrected visual acuity of 20/200 or less

☐ Visual field of 20 degrees or less

☐ Significant uncorrectable low vision affecting safety, independence, or daily activities

If dependent is under 18 years old, a parent/guardian must sign this document.

I understand the Meta Smart Glasses are provided for my intended personal use and may not be transferred or assigned to another individual.

Applicant Signature: _____ Date: _____

Parent/Guardian Signature: _____ Date: _____

FOR OFFICE USE ONLY

Serial Number: _____

Delivery Method: ☐ In Person ☐ Mail

Decision: ☐ Approved ☐ Denied

Reason: _____

State Quartermaster Signature: _____ Date: _____

State Adjutant Signature: _____ Date: _____