SURGEONS FOR SIGHT

www.surgeonsforsight.org

APPLICATION FOR EYE CARE OR GLASSES

Surgeons for Sight is a Christian, non-profit organization providing eye care to disadvantaged people. We are funded by donations, and eye care is provided by volunteer doctors and nurses.

Am I eligible for services from Surgeons for Sight?

Our guidelines are that total household gross income is less than certain poverty levels, you have NO insurance (including Medicaid, Medicare, or Obamacare) and do not have significant resources to pay for eye care.

Most of our staff are volunteers but we do have costs for medications, eyeglasses and supplies. We ask each client to pay what they can afford even if the amount may seem insignificant.

How can I apply for the program?

1. Fill out ALL sections of this application and provide us with **ALL** of the information below.

- ☐ Current Pay-stub, Social Security, Disability Stub, Food Stamp, Government Assistance, Letter from employer, or documentation to prove monthly finances
- ☐ Federal tax return from most recent year
- ☐ Bank statements for 2 recent months
- ☐ COPY of ONE Form of Identification (Driver's License, State ID, Passport, Country ID, Social Security Card, or other picture ID)

This application will not be reviewed until all documents are received and it is complete. If it is determined that false information is in this application, then you may be disqualified for care with Surgeons for Sight.

SECTION A - CLIENT GENERAL INFORMATION (PLEASE PRINT)

Client Name:_____Sex: M ☐ F ☐ Age:_____

Date of Birth:_____/_____/_____Social Security Number:_____-_____-_____Race: _____

Mailing Address:_____Apt. #_____

City:_____State:_____ZIP:_____County:_____

Phone Number:_____Alternative Phone Number:_____

Marital Status: ☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed

What type of eye care do you need (circle one): Eye exam or Eye glasses or Eye surgery

Are you willing to make a donation towards the cost of your eye care? Yes No

If so, how much? _____ (Please send donation to Surgeons for Sight, PO Box 2122 Greenville SC 29602)

SECTION B - CLIENT ELIGIBILITY AND BACKGROUND INFORMATION

1. ☐ Yes ☐ No Are you receiving Social Security, Disability or Veteran's Benefits?

2. ☐ Yes ☐ No Do you have health insurance?
   a. If **YES**, check the type that you have? Medicaid Medicare

   Private Insurance Other _____

3. ☐ Yes ☐ No When did you last have an eye exam or get new glasses?
   a. _____ Where? _____

4. ☐ Yes ☐ No Have you received services from Surgeons for Sight before?_____
   a. If **YES**, which service(s)? ☐ Eye Exam ☐ Eyeglasses
      ☐ Vision Screening ☐ Surgery
   b. What was the date of these services?_____

5. ☐ Yes ☐ No Are you sponsored by a hospital? If so, which hospital? _____

SECTION C - REFERRAL AGENCY INFORMATION or HOSPITAL SPONSORED INFORMATION

Referring Agency or Hospital:_____

Name of Contact:_____Telephone #:_____

SECTION D – CLIENT FAMILY SIZE / INCOME INFORMATION

Please **PRINT** your name and the names of **all** the individuals living in your household and their income.

FIRST AND LAST NAME	AGE	RELATIONSHIP	EMPLOYED?	MONTHLY INCOME
		SELF	Y N	$
			Y N	$
			Y N	$
			Y N	$
			Y N	$
			Y N	$
			Y N	$

Do you or who you are living with? (circle one): RENT an apartment/house or OWN a house

If own a house, provide estimated: House value _____ House loan amount_____

How much money do <u>you and those that are living with you</u> have in:

a) Checking accounts _____ c) Retirement accounts _____

b) Savings accounts _____ d) Other accounts _____

MONTHLY HOUSEHOLD INCOME	**SELF**	**SPOUSE**	**OTHER**
Monthly working gross wages/pay	$	$	
Social Security Benefits	$	$	
Disability Benefits	$	$	
Retirement/Pension Benefits	$	$	
Unemployment Benefits	$	$	
Veteran's Benefits	$	$	
Federal or State Public Assistance	$	$	
Child Support/Alimony	$	$	
Food Stamps	$	$	
Other Income / Family Financial Support	$	$	
TOTAL MONTHLY INCOME	**$**	**$**	

☐ Yes ☐ No Are you able to work? If not, why?_____

☐ Yes ☐ No Are you willing to volunteer to help Surgeons for Sight?

SECTION E – SUBMITTING THE APPLICATION

All information on this application is kept in the strictest confidence by Surgeons for Sight. By signing below, I attest and certify that the information on this application is true and complete to the best of my knowledge. I also understand I may be disqualified for care if false or incomplete information is contained in this application. I also understand that I may not qualify or receive care from Surgeons for Sight.

X_____ _____

SIGNATURE OF PERSON APPLYING FOR CARE **DATE**

By signing this, I understand that I am admitting to not having any type of health insurance, Medicaid or Medicare. If at any point this changes, I am responsible to let Surgeons for Sight know in a timely manner. Failure to do so will result in personal responsibility for all costs of my bill. Partnering Physicians will be entitled to bill me or my insurance provider for services or glasses provided while insurance coverage is in place.

X _____ _____

SIGNATURE OF PERSON APPLYING FOR CARE **DATE**

This form may be mailed to: Surgeons for Sight, PO Box 2122 Greenville SC 29602
Or Faxed to: *866-278-5655*