www.servantsforsight.org
864-293- 6449

PATIENT APPLICATION

Our guidelines are that total household gross income is less than certain poverty levels, applicant has NO insurance (including Medicaid, Medicare, or Affordable Health Care) and does not have significant resources to pay for eye care.

Documents and Requirements for Application

__**Verification of Income -**From each member of the household that receives any income; including current Pay-stub, Social Security Award Letter, Disability Letter, Food Stamp Statement, Letter from employer or Other

__ **Most Recent Federal Tax Return**

__ **COPY of ONE Form of Identification for Applicant:** Driver's License, State ID, Passport, Country ID, Social Security Card, or other picture ID

Application Process:

1. Mail Application, Verification of income documents, and Copy of ID to: **Servants for Sight, PO Box 2122 Greenville SC 29602 Or Fax documents to:*866-278-5655.***
2. Application will be processed within 2 to 3 weeks
3. Applicant will be called for a phone interview and verification of documents. If applicant is applying for surgery, an in-person interview may be required.
4. If applicant is approved they will be sent to a volunteer physician and the physician's office will take over patient care and scheduling.
5. At patient's first appointment, patient will be required to contribute partial payment for their care. Eye exam is 5 dollars and glasses are 15 dollars. Cataract surgery is 50 dollars (*If you reapply for a second cataract surgery and it is determined that your situation merits another qualification, the second surgery will also be 50 dollars).
6. Servants for Sight does not guarantee to cover all medical eye care issues, we strive to provide exams, glasses, and cataract surgeries for approved applicants. Any follow up appointments or ongoing care needed will be determined by the physician. SFS will only consider a patient for an additional approval if there is a medical emergency or long-lasting medical condition. This is determined on a case by case basis.

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 all that apply): Eye exam or Eye glasses or Eye surgery

SECTION A- 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
   b. 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. Please explain the medical reason for re-applying for SFS: ______________

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

SECTION B- REFERRAL AGENCY INFORMATION or HOSPITAL SPONSORED INFORMATION

Referring Agency or Hospital:____

Name of Contact:__________________________________Telephone #:__________________________

SECTION C- 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	$

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 you and those that are living with you have in:

a) Checking accounts ______________ b) Savings accounts______________

c) Retirement accounts ______________ d) Other accounts ______________

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

☐ Yes ☐ No Do you have any marketable skills? If yes please specify: _________________________

SFS tries to make connections to employers on behalf of SFS clients if applicable

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

MONTHLY HOUSEHOLD INCOME	**SELF**	**SPOUSE**	**Other Family Member**	**Other Family Member**	**Other Family Member**
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	**$**	**$**			

All information in this application is kept in the strictest confidence by Servants for Sight. By signing below, I attest and certify that the information in 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 Servants for Sight. I understand that Servants for Sight will try to connect me with eye care providers, but that my eye care needs are not guaranteed to be met.

I understand that if my conduct during SFS coverage is not compliment or respectful, I may be discharged from the program and physician services. I understand that I am admitting to not having any type of health insurance, including Medicaid or Medicare. If at any point this changes, I am responsible to let Servants for Sight know in a timely manner. Failure to do so will result in personal responsibility for all costs of my bill. I understand that partnering physicians and SFS 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 and accompanying documents may be mailed to: <u>Servants for Sight, PO Box 2122 Greenville SC 29602</u> Or Faxed to: *866-278-5655*