Servants for Sight Patient Eye Care Application

Required Documents

All documents are required for application.

1. _____ Verification of Income
    a. From every member of the household that receives any income. Include the last 4 pay-stubs, social security award letter, disability letter, food stamp statement, or letter from employer.
2. _____ Most Recent Federal Tax Return
3. _____ COPY of ONE Form of Identification for Applicant
    a. Driver's License, State ID, Country ID, or Social Security Card

Application Process

Mail completed application, documents, and copy of ID to: Servants for Sight
P.O. Box 2122
Greenville, SC 29602

Or fax documents to: 866-278-5655

Application will be processed within 2 - 3 weeks and will be called for a phone interview/verification of documents.

If applicant is approved, they will be required to attend a program orientation class. The class will describe our program and provide educational material on eye care, eye diseases, and treatments.

If applicant wants to join our program, there is a $25 fee. When this fee is paid, the applicant will be scheduled to see one of our volunteer physicians.

Servants for Sight does not guarantee to cover all medical eye care issues. Our goal is to provide exams, glasses, and cataract surgeries within a 9 month period. 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.

Patient Information

Name:_____ Sex: M ☐ F ☐ Age:_____

Date of Birth: / / Ethnicity: _____

Mailing Address:_____ Apt. # _____

City:_____ State:_____ ZIP: _____

Phone Number: _____ Alternative Phone Number: _____

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

Preferred Language: _____

Do you have a translator? (Name/Phone if applicable): _____

Are you affiliated with another program or ministry? ☐ Yes ☐ No

If so, which one? _____

Eye Health

What type of eye care do you need (circle all that apply): Eye exam Eye Glasses Eye Surgery

Has someone told you what is wrong with your eyes? If so, what? _____

Do you have a family history of Glaucoma? ☐ Yes ☐ No

Are you seeing flashes or sparks? ☐ Yes ☐ No

Are you seeing floaters or specs? ☐ Yes ☐ No

Do you have a history of high blood pressure? ☐ Yes ☐ No

Do you have diabetes? If so, what type? _____

Have you been told that you are prediabetic? ☐ Yes ☐ No

Do you smoke? ☐ Yes ☐ No

Emergency Contact Information

Name: _____ Contact Number: _____

Secondary Number: _____ Relationship to Contact: _____

Eligibility and Background Information

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

2. Do you have health insurance? ☐ Yes ☐ No

   a. If YES, check the type that you have? _____ Medicaid _____ Medicare

   b. Private Insurance_____

   c. Other_____

3. When did you last have an eye exam or get new glasses? _____

   Where? _____

4. Have you received services from Surgeons for Sight before? ☐ Yes ☐ No

   a. If YES, which service(s)? ☐Eye Exam ☐Eyeglasses ☐Vision Screening ☐Surgery

   b. Please explain the medical reason for re-applying for SFS: _____

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

Referral Agency Information Or Hospital Sponsored Information

Referring Agency or Hospital: _____

Name of Contact: _____

Phone #: _____

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	$

1) Do you pay rent?: ☐ Yes ☐ No If yes, how much? _____

2) If not, do you own a home or pay a mortgage? ☐ Yes ☐ No

If yes, how much? _____

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

4) What skills do you have or what services could you provide to help another person in your situation?

*(SFS tries to make connections to employers or others in need on behalf of SFS clients.)*_____

_____

_____

5) Are you willing to volunteer with us or another similar organization? ☐ Yes ☐ No

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 inappropriate or disrespectful, 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 required to let Servants for Sight know in a timely manner. Failure to do so will result in personal responsibility for all medical costs. 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

Please make sure to bring your photo ID to all doctors appointments!