2021 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 3-4 weeks and will be called for a phone interview/verification of documents.

If an 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 an applicant wants to join our program, they will be expected to pay a small program 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 within that 9 month period of time. After the 9 month period, the patient will be expected to pay for their eye care themselves.

Patient Information

Name:_____ Sex: M ☐ F ☐ Age:_____

Date of Birth: / / Ethnicity: _____

Mailing Address:_____ Apt. # _____

City:_____ State:_____ ZIP: _____

Phone Number: _____ Alternative Phone Number: _____

Email: _____ Social Security Number: _____ - _____ - _____

Preferred Language: _____

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 diabetes? If so, what type? _____

Do you smoke? ☐ Yes ☐ No

Emergency Contact Information

Name: _____

Relationship to Contact: _____

Contact's Phone Number: _____

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 or Servants for Sight before? ☐ Yes ☐ No

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

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.

1) How many people live with you in your home? _____

2) Do you own a home or pay a mortgage? ☐ Yes ☐ No If yes, how much? _____

3) If not, who pays your rent? ☐ Self ☐ _____

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

_____

5) If you don't currently work, with improved vision, do you plan to go back to work? ☐ Yes ☐ No

If not, why? _____

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

P.O. Box 2122, Greenville, SC, 29602 | Phone 864.249.7037 | Fax 866.278.5655 | info@servantsforsight.org

Clemson Eye

Spartanburg VISION
Our Vision is to Protect Yours

servants FOR SIGHT

POOLE FAMILY EYE CARE

Southern Eye Associates

PalmettoEye & LASER CENTER

RELEASE AND ACKNOWLEDGMENT OF CHARITABLE MEDICAL SERVICES WITHOUT COMPENSATION

The undersigned patient wishes to receive an eye examination, eyeglasses, or surgical procedures from a Servants for Sight partnered physicians office (Practice), who has voluntarily agreed to provide such services with no compensation. This release and acknowledgement has been made before the rendering of medical services. The undersigned patient acknowledges that the liability, if any, of practice and the physician is limited under South Carolina law and Federal law.

To the extent allowed by South Carolina law, the undersigned patient releases the practice and physician(s) for free medical services from any and all claims, demands, debts, rights, actions, causes of action, costs, loss of service, companionship, consortium, property damage, fees, expenses and compensation of whatsoever nature, now existing or which may hereinafter accrue, and all known and unknown, foreseen and unforeseen damages and the consequences thereof resulting which heretofore have been, or which hereinafter may be, sustained by the undersigned as a result of any charitable medical services rendered to the undersigned patient by the practice or physician. The undersigned patient acknowledges that the charitable medical services received is fair and is adequate consideration for this release of liability.

_____ _____
Date Patient's or Responsible Party's Signature

_____ _____
Date Witness

Please initial next to each statement to indicate your agreement and understanding.

_____I understand that the practice and physician are providing medical services without compensation, and that I may be discharged as a patient at the end of my 9 month eligibility period if I do not have insurance or alternate payment options.

_____ I understand that the practice and physician are providing an eye examination that could result in findings that could require medications, surgery or other tests and procedures. The practice and physician are not required and may not be able to provide my entire medical and eye care needs, with or without compensation. I release the practice from all liability for continued care or follow up of any condition treated or discovered during my 9 month eligibility period.