



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?

We review each application to make a determination of who gets care. Our general guidelines are that your total household gross income must be less than certain poverty levels, you have no insurance and you do not have significant available resources to pay for eye care.

Our staff are volunteers but we do have costs for medications, eyeglasses and supplies. We ask each client to pay what they can afford. Any amount paid goes toward your eye care.

How can I apply for the program?

1. Fill out ALL sections of this application and provide us the information below.
 - Current Paycheck Stub, Social Security, Disability or Pension/retirement payment stub
 - Federal tax return
 - COPY of ONE Form of Identification (Driver's License, Social Security Card, or other picture ID)
2. This application will not be reviewed until all qualifying documents are received.

SECTION A - CLIENT GENERAL INFORMATION (PLEASE PRINT OR TYPE)

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: _____

Client 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

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
 County Health Card Private Insurance Other Health
3. Yes No When did you last have an eye exam or get new glasses?
 - a. _____
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? _____

SECTION C - REFERRAL AGENCY INFORMATION (IF CLIENT WAS REFERRED BY AN AGENCY)

Referring Agency: _____

Name of Contact: _____ Telephone #: _____

SECTION D – CLIENT FINANCIAL 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	<input type="checkbox"/> Y <input type="checkbox"/> N	\$
			<input type="checkbox"/> Y <input type="checkbox"/> N	\$
			<input type="checkbox"/> Y <input type="checkbox"/> N	\$
			<input type="checkbox"/> Y <input type="checkbox"/> N	\$
			<input type="checkbox"/> Y <input type="checkbox"/> N	\$
			<input type="checkbox"/> Y <input type="checkbox"/> N	\$
			<input type="checkbox"/> Y <input type="checkbox"/> N	\$

Do you? (circle one) RENT an apartment/house or OWN your home

If you own your home, please provide: Home value _____ Home loan amount _____

How much money do you have in savings and bank accounts? _____

MONTHLY HOUSEHOLD INCOME	SELF	SPOUSE	OTHER
Take-Home Pay	\$	\$	
Hourly Pay Rate	\$	\$	
Tips	\$	\$	
Social Security Benefits	\$	\$	
Disability Benefits	\$	\$	
Retirement/Pension Benefits	\$	\$	
Veteran's Benefits	\$	\$	
Unemployment Benefits	\$	\$	
Federal or State Public Assistance	\$	\$	
Child Support/Alimony	\$	\$	
Food Stamps	\$	\$	
Other Income	\$	\$	
TOTAL MONTHLY INCOME	\$	\$	

Yes No Are you able to work?

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 and agencies associated with our programs. By signing below, I attest that the information on this application is true and complete to the best of my knowledge. I also agree to the following:

1. I have disclosed all information about my ability to pay and my financial information.
2. I understand that I may not qualify or receive care from Surgeons for Sight.

This form may be mailed to: Surgeons for Sight, 104 Simpson St., Greenville, S.C. 29605

 X
SIGNATURE OF CLIENT OR LEGAL GUARDIAN _____ DATE _____

For office use only (screener signature _____ and date _____):
All documents received/verified _____ Eligible _____

Comments: