Gift of Sight Program

Mission:

The Eye Center South Gift of Sight program exists to provide Cataract Surgery to select individuals in the community who are in need of Cataract Surgery and otherwise could not afford to have this surgery performed.

General Information:

This service is provided by several Doctors at Eye Center South who graciously give of their time to give back to the community. All applicants for this program are required to be referred by an Optometrist. Only one eye is eligible for the Gift of Sight Program. The following requirements were created to ensure that each individual who is chosen for this gift has a true financial and medical need.

Eligibility requirements:

1. Vision of 20/70 or higher in the eye that patient wishes to have surgery on.
2. Proof that financial situation merits consideration for the surgery. Applicant will be asked to write a paragraph or two stating why they feel their financial situation should make them eligible for this gift. (Family member or friend can write this if patient is not able). Applicant will also be required to provide documentation of their income and monthly budget. A copy of prior year federal Income tax return and a current bank statement will also be required.
3. Applicant must fill out a copy of the Eye Center South hardship form.
4. Applicant must make a vision screening appointment at Eye Center South to verify that there is a true medical need for this gift. There will be no charge for this visit.
5. Referral from an Optometrist is required to participate in this program.
6. Applicant can't currently have or be eligible for any type of health insurance.
7. Applicant must complete the application and monthly household worksheet on the following 2 pages.
8. Applicant can't have previously had free cataract Surgery through the Eye Center South Gift of Sight Program. Only one eye is eligible for the Gift of Sight program.

Gift of Sight Application

Patient Name____

Address____

Date of Birth:____

City_______________State_______________Zip _____________________________________

Home Phone number (_____)____

Alternate phone number (_____)____

Social Security Number ____

Do you have Health Insurance?

____

Are you eligible for any type of Health Insurance?_________________________________

Who in your household is currently employed?_______________________________

How many dependent children live in the Household?_________________________

What is your total Household Income? _______________________________________

What is the total number of people in your household?_______________________

What is the name of the Optometrist who referred you?

____

Is patient or spouse confined to a bed or wheelchair? ________________________

Is patient or spouse now in a nursing home? _________________________________

Have you ever had a free Cataract Surgery through our program before? ____________

Monthly Household Budget Worksheet	Self Amount	Spouse or other Household Members	Total monthly amount
Monthly Income(all sources)			
Salaries/Wages			
Social Security			
Retirement			
Aid for family with dependent children			
Food Stamps			
Other			
Total			
Monthly Bills			
	Monthly Payment		
Rent/Mortgage			
Car payment(s)			
Health Insurance Premiums			
Car Insurance Premiums			
Food			
Electricity			
Gas(home use)			
Phone			
Water/Sewage			
Cable/Satellite			
Garbage			
Credit Card Payment(s)			
Loan payment(s)			
Medication			
Medical Bill #1			
Medical Bill#2			
Other			
Other			

I certify by signing below that I have answered all questions on this application truthfully and to the best of my knowledge. I understand that if I am selected as a recipient of this program, that I will only be eligible to have free cataract surgery on one eye.

Applicant Signature: ____

Date:____

Please be assured that all personal information will be kept completely confidential.