



# 2019 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**

Client 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 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

<b>MONTHLY HOUSEHOLD INCOME</b>	<b>SELF</b>	<b>SPOUSE</b>	<b>Other Family Member</b>	<b>Other Family Member</b>	<b>Other Family Member</b>
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	\$	\$	\$	\$	\$
<b>Total Monthly Income</b>	\$	\$	\$	\$	\$

