July 2019

Please print clearly in ink and return with the required documents to:
7155 Old Katy Road, Suite N100 - Houston, Texas 77024
Phone (713) 558-8740 Fax (713) 395-1666
heaf@houstoneye.com

Patient Name _____ **Date:** _____
(First Name Last Name)

Are you a current HEA Foundation patient? _____ _____
Name of Parent (if patient is under 18)

Who referred you to HEAF?_____ **Who is your physician?** _____

_____ _____ (____)_____ (___)_____
Birth Date **Social Security Number** **Home Phone** **Cell Phone**

Address_____
City **State** **Zip**

_____ _____ _____ _____
Total number of persons in household **Number of wage earners in household** **Yearly household income** **County of residence**

Optional: □White/Anglo □Black/African-American □ Hispanic/Latin □Asian □ Other
□ Male □ Female

PLEASE ANSWER YES OR NO:
1. Do you have health insurance? _____
2. Do you have Medicare? ____ Do you have Medicaid? ____ If NO, have you applied for it? _____
3. Do you have county medical assistance? _____ If NO, have you applied previously? _____
4. Are you currently employed? _____ If NO, is your unemployment due to vision issues? _____
5. Do you live in Texas permanently? _____ 6. Does your household file income taxes? _____
7. Have you exhausted other available options, such as: 401k, retirement fund, assets, available funding from family, or friends? _____

For what type of medical eye problem are you seeking help? _____

Which Program Are You Applying For?
□ Surgical/Medical Specialty Program □ Eye Care for Kids Vision Program (only for patients 21 and under)

Please list the amount of your monthly expenses: Rent/Mortgage_____ Electricity_____ Telephone _____

Food_____ Car _____Child Support (if applicable) _____

I understand that if I qualify as a HEAF patient, my status as a HEAF patient may be IMMEDIATEY revoked if I fail to disclose all financial assets or if the Foundation becomes aware of undisclosed and available financial support while benefitting from HEAF's donated services. I also am confirming that I live in Texas permanently and the information listed above is accurate to the best of my knowledge:

_____ _____
Applicant's Signature or Legal Representative Date

_____ _____
Patient or Legal Representative Name (print) Relationship to Applicant if Legal Representative

July 2019

Houston Eye Associates Foundation
Patient Compliance Form

I, _____ (print patient name), understand if accepted for Foundation assistance, I must comply with the following terms or can be terminated from the program:

1. **Show up on time.** Physicians donate their time and services for your treatment. Please be respectful of their schedule as they also have a private practice with other scheduled appointments.

   Patient Initials: _____

2. **Avoid cancellations.** If you are unable to attend your appointment for whatever reason, you must contact your physician's office to reschedule a minimum of 24 hours in advance.

   Patient Initials: _____

3. **Follow your physician's orders.** You must follow your physician's orders through the entirety of your foundation status, including attending all appointments deemed medically necessary and follow through with all treatment plans.

   Patient Initials: _____

4. **Patient is responsible for transportation and lodging, if needed.** While Eye Care Services are covered 100%, you acknowledge that you are responsible for your own transportation to and from appointments. If coming from out of town, you acknowledge that you are responsible for your own lodging accommodations if you need to spend the night.

   Patient Initials: _____

Please note that physicians and other local medical professionals **donate** their medical/surgical services and office visits to you. The Houston Eye Associates Foundation pays for hospital and surgical facility fees, glasses, and other ancillary expenses on your behalf.

I have read, understand, and agree to comply with this policy. I understand if I fail to comply with the above mentioned policies, my foundation status can be terminated.

_____ _____
Applicant's Signature or Legal Representative Date

_____ _____
Patient or Legal Representative Name (print) Relationship to Applicant if Legal Representative

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HOUSTON EYE ASSOCIATES FOUNDATION

July 2019

Please submit the following REQUIRED documents along with this completed application:
Do not send originals. HEAF office will not photocopy and return any documents.

For Applicants Applying for Surgical/Medical Specialty Program:

☐ REQUIRED - Denial letter from residing county indigent health program.
- Applicant must have applied and showed proof of currently denied county medical assistance from the county in which they reside in. Below are the most commonly requested county phone numbers:

Angelina County	936-634-5431	Jasper County	409-423-6935
Bexar County	210-358-3350	Jefferson County	409-835-8530
Brazoria County	979-864-1884	Matagorda County	979-244-8134
Cameron County	956-389-3672	Montgomery County	936-523-5101
Collin County	972-548-4702	San Jacinto County	936-653-2091
Dallas County	214-590-6013	Smith County	903-526-4405
Fort Bend County	281-341-6624	Tarrant County	817-702-1001
Galveston County	409-949-3439	Travis County	512-978-8130
Harris County	713-566-6509	Waller County	979-826-7730
Hunt County	903-408-1121	Wharton County	979-595-2800

☐ REQUIRED - Copy of most recent household tax return.

☐ REQUIRED - Copy of the last two paystubs that includes year to date figures for all working individuals in the household, or a handwritten letter from employer. If self-employed, please provide a self-employment letter confirming occupation type and monthly gross income. If unemployed, a copy of any financial award letters from disability, social security, or unemployment offices. If unemployed and living with family members, send proof of household income for the family and letter from family confirming they are financially supporting the applicant.

☐ REQUIRED – If applicant has private, medical insurance, a copy of the insurance card, and insurance plan that states what the deductible is, is required.

☐ IF applicant is under 18 years of age or over 65 years of age, a denial letter from Medicaid/Medicare is required.

☐ IF applicant is receiving disability income, a denial letter from Medicaid/Medicare is required.

For questions regarding the Surgical/Medical Specialty Program:
Ashley Herrera, Program Services Coordinator
(Tel) 713-558-8740
(Fax) 713-395-1666
aherrera@houstoneye.com

For Applicants Applying for Eye Care for Kids Vision Program:

☐ REQUIRED - Copy of most recent household tax return.

☐ REQUIRED - Copy of the last two paystubs that includes year to date figures for all working individuals in the household, or a handwritten letter from employer. If self-employed, please provide a self-employment letter confirming occupation type and monthly gross income. If unemployed, a copy of any financial award letters from disability, social security, or unemployment offices. If unemployed and living with family members, send proof of household income for the family and letter from family confirming they are financially supporting the applicant.

☐ IF applicant is under 18 years of age, a denial letter from Medicaid required.

☐ IF applicant is receiving disability income, a denial letter from Medicaid/Medicare is required

For questions regarding the Eye Care for Kids Vision Program:
Sonji Mims, Program Services Coordinator
(Tel) 713-668-6828 ext. 2951
(Fax) 713-395-1666
smims@houstoneye.com