April 2017

HOUSTON EYE ASSOCIATES FOUNDATION

7155 Old Katy Road, Suite N100 - Houston, Texas 77024
Phone (713) 558-8740 Fax (713) 395-1666
www.houstoneye.com/foundation
heaf@houstoneye.com

ABOUT THE FOUNDATION

The Houston Eye Associates Foundation (HEAF) was formed in 1981 as a 501(c)3 non-profit organization by a group of Houston Eye Associates ophthalmologists and **serves as a last resort organization for those who are denied medical eye care services anywhere else** (through their county or government programs.) The physicians donate their office time and surgical skills while the HEAF pays for surgery center fees, vision-saving medications and ancillary expenses for *qualified* patients. HEAF assistance must be renewed on an annual basis.

SEEKING EYE GLASSES OR AN EYE EXAM?

For those in need of low-cost eye exams and discounted glasses, call University of Houston Good Neighbor Clinic at (713) 527-8480. For those needing eyeglasses, please call The Lion's Club at (713) 796-2960 or Prevent Blindness Texas at (713) 526-2559.

WHO QUALIFIES: *To qualify for HEA Foundation assistance, the following conditions must be met:*

a) Applicant must have applied and show proof of currently denied county medical assistance. **Applications from any county are accepted.** Below are the most commonly requested county phone numbers.

Angelina County	936-634-5431	Hardin County	409-246-5189
Brazoria County	979-864-1884	Harris County	713-566-6691
Bexar County	210-358-3171	Liberty County	936-336-4693
Chambers County	409-267-8306	Matagorda County	979-245-8421
Colorado County	979-732-9453	Montgomery County	936-523-5100
Fort Bend County	281-341-6624	Orange County	409-882-7838
Galveston County	409-770-5550	San Jacinto County	936-653-2091
Gillespie County	830-990-7567	Trinity County	936-642-1736
Jasper County	512-458-7706/409-423-6935	Waller County	979-826-7730
Jefferson County	409-835-8530/409-983-8380	Wharton County	979-595-2800

b) Applicant must fall below a set financial guideline defined by the Federal Poverty Levels. Documentation and confirmation of household income and dependents must be provided with application.

c) Denial letters from Medicare and Medicaid are only required for the following situations:
   - If applicant is receiving disability income.
   - If applicant is over 65, a denial letter from **Medicare** must be included with this application. Call 1-800-772-1213 or 866-539-5598 to begin the Medicare process.
   - If applicant is 18 and under, a denial letter from **Medicaid** must be included with this application. Call 1-800-252-8263 or 800-925-9126 to begin the Medicaid process.

d) Applicant must live in Texas permanently.

TO APPLY

Complete this HEA Foundation application and send with all the following REQUIRED documents:

- ☐ REQUIRED - Denial letter from residing county indigent health program.
- ☐ REQUIRED - Copy of household 2016 1040 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 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, a denial letter from Medicaid is required.
- ☐ IF applicant is over 65 years of age, a denial letter from Medicare is required.
- ☐ IF applicant is receiving disability income, a denial letter from Medicare/Medicaid is required.

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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?** _____

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

_____ _____ (____)_____ (____)_____ (___)_____
Birth Date **Social Security Number** **Home Phone** **Work 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: ☐Anglo ☐African-American ☐ 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. Do you file income taxes? _____
7. Have you exhausted other available options, such as: 401k, retirement fund, assets, available funding from family, or friends? _____

Please submit the following REQUIRED documents along with this completed application:

Do not send originals. HEAF office will not photocopy and return any documents.

☐ REQUIRED - Denial letter from residing county indigent health program.

☐ REQUIRED - Copy of household 2016 1040 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 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 Medicare/Medicaid is required.

_____ _____ _____
Your Employer Position Yearly gross income

_____ _____ _____
Spouse's Employer (If applicable) Position Yearly gross income

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 **Date**

April 2017

Houston Eye Associates Foundation
Patient Compliance Form

I, _____ (print 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: _____

Please note that the physicians of Houston Eye Associates and other local medical professionals are **donating** their surgical services and office visits to you. The Houston Eye Associates Foundation pays for hospital and surgical facility fees 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.

Signature: _____ **Date: _____**

Printed Name: _____

If you have any questions, please feel free to contact the Foundation office at (713) 558-8740.

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Please complete this document ONLY if the applicant is not employed.
Por favor completa esta pagina si no trabaja el aplicante.

STATEMENT OF SUPPORT

If someone other than your spouse supports you, he/she must fill out this form:

I, _____(name of supporter) have supported _____

(client's name) for this long (**Example 4 months**):_____.

□**I do** □**I do not** give him/her room and board.

□**I do give** him/her $_____ □Weekly □Every 2 weeks □Twice monthly □Weekly

My relationship to him/her is_____. I understand that I am not responsible for his/her medical bills unless I have a legal responsibility to support him/her. I receive income from

_____.

Signature: _____ Date: _____

Printed Name: _____ Telephone Number: _____

DECLARACIÓN DE AYUDA FINANCIERA

Si recibe ayuda de otra persona que no sea su cónyuge, esa persona deberá completar este formulario:

Yo, _____ (nombre de quién brinda ayuda financiera) he ayudado a

_____ (nombre del cliente) durante (**Ejemplo: 4 meses**):_____.

□**Yo le otorgo** □ **Yo no le otorgo** alojamiento y comida.

□ **Yo le otorgo $_____** □ Semanal □ Cada dos semanas □ Bi-mensual □ Mensual

Mi relación con él/ella es _____. Comprendo que no soy responsable del pago de sus cuentas médicas salvo que tenga la responsabilidad legal de mantenerlo/a. Recibo ingresos de

_____.

Firma: _____ Fecha: _____

Nombre en imprenta: _____ Teléphono: _____

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