HOUSTON EYE ASSOCIATES FOUNDATION

A nonprofit organization committed to preserving and restoring sight, Houston Eye Associates Foundation offers two programs with a unified goal, to remove economic barriers to quality, comprehensive, and compassionate, medically related vision care for Texans in need.

APPLICATION Please complete and return with supporting documents by mail, email, or fax to:

Address: Houston Eye Associates Foundation/ 7155 Old Katy Road, Suite S110 / Houston, TX 77024

Email: heaf@houstoneye.com **Telephone:** 713.558.8740 **Fax:** 713.558.8760

Please indicate which program you are applying for

☐ Surgical /Medical Specialty Program

NO COST VISION-RELATED SURGICAL/MEDICAL CARE FOR UNDER-INSURED, LOW-INCOME TEXANS (ALL AGES)

MEDICAL EYE PROBLEM?_____

OTHER EYE CONDITIONS?_____

PATIENT IS DIABETIC? ☐ YES ☐ NO

DATE OF LAST EYE EXAM _____

☐ Eye Care for Kids Vision Program

NO COST EYE EXAMS AND GLASSES FOR LOW-INCOME, HOUSTON-AREA STUDENTS (5-21 YEARS OLD)

STUDENT LIVES IN TEXAS PERMANENTLY YES | NO

STUDENT CURRENTLY WEARS GLASSES YES | NO

DATE OF LAST EYE EXAM _____

STUDENT'S SCHOOL _____ GRADE_____

STUDENT'S SCHOOL DISTRICT_____

REQUIRED PATIENT APPLICANT INFORMATION FOR BOTH PROGRAMS

ARE YOU A PAST OR CURRENT HOUSTON EYE ASSOCIATES PATIENT? ☐ YES ☐ NO

HAVE YOU APPLIED TO THE HOUSTON EYE ASSOCIATES FOUNDATION IN THE PAST? ☐ YES ☐ NO

APPLICANT: _____ _____ _____

FIRST NAME MIDDLE INITIAL LAST NAME

____/___/_____ _____ _____ (_____)_____ (_____)_____

Birth Date Age Email Home Phone Cell Phone

_____ _____ **TEXAS** _____ _____

Address City Zip Code County

_____

Apartment/Unit #

PARENT/GUARDIAN: _____ _____ _____

IF APPLICANT IS UNDER 18 YEARS FIRST NAME MIDDLE INITIAL LAST NAME

TOTAL HOUSEHOLD MEMBERS____ TOTAL HOUSEHOLD WAGE EARNERS _____

HOUSEHOLD INCOME $_____ / Year

1) Does applicant have health insurance? ☐ YES ☐ NO If YES, insurance provider name_____
If insured, include copies of the front and back of the patient's insurance card

2) Does applicant have Medicare, Medicaid, or CHIP? ☐ YES ☐ NO If NO, has applicant applied for it? ☐ YES ☐ NO

3) Does applicant have county medical assistance? ☐ YES ☐ NO If NO, has applicant applied previously? ☐ YES ☐ NO

4) Is applicant employed? ☐ YES ☐ NO If NO, is unemployment due to vision issues? ☐ YES ☐ NO

5) Does applicant live in Texas permanently? ☐ YES ☐ NO

6) Does applicant's household file income taxes? ☐ YES ☐ NO

7) Does applicant have other support, i.e., assistance from friends or family, savings,401K, retirement funds? ☐ YES ☐ NO

Please list monthly expenses: Rent/ Mortgage_____ Electric & Gas_____ Telephone _____ Food _____ Auto_____
Child Support (if applicable) _____

REQUIRED PATIENT APPLICANT HOUSEHOLD INFORMATION

Name of each household member*	Applicant Relation: legal/ common law spouse, child (under 18 years), other	Age	Employed	Monthly Income	Employer / Income Source
1.	myself		☐ YES ☐ NO		
2.			☐ YES ☐ NO		
3.			☐ YES ☐ NO		
4.			☐ YES ☐ NO		
5.			☐ YES ☐ NO		
6.			☐ YES ☐ NO		

**List additional household members and information on a separate piece of paper.*

If anyone in the household is of working age, and not employed, please explain:

_____

_____

_____

REQUIRED COMPLETED ATTACHMENTS INCLUDE:

◯ **APPLICATION SUPPORT CHECKLIST with required supporting documents dated within the past twelve (12) months.**

◯ **PATIENT COMPLIANCE FORM, initialed and signed.**

OPTIONAL DEMOGRAPHIC INFORMATION

To fulfill its mission, the Foundation relies on donations and grants. The following information helps secure this support.

APPLICANT GENDER: ☐ Female ☐ Male ☐ Other **PREFERRED PRONOUN:** ☐ She ☐ He ☐ They

APPLICANT RACE/ETHNICITY:

◯ Asian/ Asian Indian / Middle Eastern ◯ Hispanic / LatinX ◯ American Indian / Alaskan Native ◯ Mixed Race

◯ Black / African American ◯ White / Caucasian ◯ Native Hawaiian / Pacific Islander ◯ Other

REQUIRED CERTIFICATION

I understand that if I qualify, status as a HEA Foundation patient may be IMMEDIATELY revoked for failure to disclose all financial assets, or if the Foundation becomes aware of undisclosed financial support while receiving HEA Foundation services. I am confirming that I live in Texas permanently and reported information is accurate to the best of my knowledge.

_____ _____

Signature of applicant or parent/guardian/legal representative **Date**

_____

Printed Name

☐ I am completing this application for myself or my child

☐ This application is completed for me by _____ _____

Name of representative **phone number**

AUTHORIZATION TO DISCLOSE INFORMATION

I authorize the following individual(s) or organization to disclose the above-named applicant's information:

_____ _____

_____ _____

_____ _____

NAME PHONE NUMBER

REQUIRED APPLICATION SUPPORT CHECKLIST: SURGICAL/ MEDICAL PROGRAM

Please submit the following REQUIRED documents along with this completed application:
Do not send originals. HEAF office will not photocopy and return any documents.
All reporting documents must be dated within the past twelve (12) months.

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

Applicant must have applied and shown proof of currently denied county medical assistance from the county in which they reside in. Below is a contact list the most populous counties. For a complete list, call (800)-222-3986 Extension 6467 or visit: https://www.hhs.texas.gov/services/health/county-indigent-health-care-program

County	Program Name	Phone Number
Harris	Harris Health Financial Assistance Program (Gold Card)	(713) 566-6509
Dallas	Parkland Financial Assistance (PFA)	(214) 590-8831
Bexar	CareLink Program	(210) 358-3350
Travis	Medical Access Program (MAP)	(512) 978-8130
Collin	County Indigent Health Care Program	(972) 548-4702
Denton	County Indigent Health Care Program	(940) 349-2940
Hidalgo	County Indigent Health Care Program	(956) 318-2011
Fort Bend	County Indigent Health Care Program	(281) 341-6624
Montgomery	Health Care Assistance Program (HCAP)	(936) 523-5100
Galveston	County Indigent Health Care Program	(409) 949-3439

☐ **REQUIRED – Copy of most recent household tax return for each filing household member**

☐ **REQUIRED** – **Household Financials & Income Verification**

- ☐ Copy of two (2) most recent pay stubs/statements for each household wage earner member
- ☐ **If self-employed,** provide a letter confirming occupation and gross monthly income OR three (3) months of bank statements
- ☐ **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
- ☐ **If unemployed and living independently,** provide a letter confirming support (see sample)
- ☐ **If living in a group home or shelter,** please include a letter of residence on agency letterhead
- ☐ **If receiving disability**, please include award letter and start date of receiving SSID benefits. For workers compensation, include letter with wage replacement information.
- ☐ **If unemployed and living off savings/retirement**, please provide bank statements for last three (3) months.

☐ **REQUIRED** –IF applicant has private, medical insurance, please provide a copy of insurance plan that states deductibles and copy of insurance card

☐ **REQUIRED** - IF applicant is under 18 years **OR** over 65 years, a denial letter from Medicaid/Medicare is required.

Denial letter 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.

FOR QUESTIONS REGARDING THE SURGICAL/MEDICAL PROGRAM CONTACT

Ashley Palacios, Program Services Coordinator
TELEPHONE: 713-558-8740 FAX: 713-558-8760
EMAIL: aherrera@houstoneye.com

REQUIRED APPLICATION SUPPORT CHECKLIST: EYE CARE FOR KIDS VISION PROGRAM

Please submit the following REQUIRED documents along with this completed application:
Do not send originals. HEAF office will not photocopy and return any documents.
All reporting documents must be dated within the past twelve (12) months.

Eye Care for Kids Vision Program partnership with area doctors who volunteer vision exams for students (5-21 years) and provides them with glasses at no cost to the patient or their families. Most health insurance programs including CHIP, Medicare, and Medicaid provide coverage for this vision care.

☐ **REQUIRED** – Copy of most recent household tax return.

☐ **REQUIRED** – Household financials

- Copy of the most recent two paystubs that include year-to-date income for all working individuals in the household. If no pay stubs are available, a handwritten letter from employer or Letter of Employment Verification will suffice.
- If self-employed, please provide a self-employment letter confirming occupation and monthly gross income.
- If unemployed, a copy of award letters from disability, social security, or unemployment offices.
- If receiving disability, please include award letter and start date of receiving SSID benefits. For workers compensation, include letter with wage replacement information.
- If you are not working, provide a letter detailing how you pay for living expenses (*see sample*)
- If unemployed and living off savings/retirement, please provide bank statements for last three (3) months.

FOR QUESTIONS REGARDING EYE CARE FOR KIDS VISION PROGRAM CONTACT

Sonji Mims, Program Services Coordinator
TELEPHONE: 713-558-8740
FAX: 713-558-8760
EMAIL: smims@houstoneye.com

REQUIRED PATIENT COMPLIANCE FORM

Please note that physicians and other local medical professionals donate their medical/surgical services and office visits. Private donations and grants allow The Houston Eye Associates Foundation to cover ambulatory care and surgical facility fees, glasses, and other ancillary expenses for patients.

I, _____ (print patient/guardian's name), understand if accepted for Foundation assistance, I agree to the following terms or I may be terminated from the program:

1. **I will arrive on time for appointments**. Physicians donate their time and services for this treatment. Please be respectful of their schedule as they also have a private practice with other scheduled appointments.
   Initials: _____
2. **I will avoid cancellations**. If you cannot attend your appointment, for whatever reason, you must contact your physician's office to reschedule *a minimum of 24 hours in advance*.
   Initials: _____
3. **Follow my 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.
   Initials: _____
4. **I am 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.
   Initials: _____
5. **I am responsible for disclosing all financial assets.** I understand that the information which I submit concerning my annual income and family size is subject to verification. I also understand that if the information which I submit is determined to be false or if I fail to notify HEAF of any changes to my insurance, such determination will result in a denial of services.
   Initials: _____

I have read, understand, and agree to adhere to the above statements. I understand failure to adhere to the above-mentioned agreements, my foundation status may be terminated.

_____ _____
Patient or Parent/Guardian Name (print) Date

_____ _____
Patient or Parent/Guardian Signature Relationship to patient

FREQUENTLY ASKED QUESTIONS ABOUT HOUSTON EYE ASSOCIATES FOUNDATION PROGRAMS

Houston Eye Associates Foundation is non-profit organization founded by Houston Eye Associates physicians to provide medical vision care to Texans in need. Physicians generously donate their time and services. Through private contributions and grants, the Foundation covers related expenses for medically necessary treatment including: surgical facility fees, medications, glasses, and ancillary services to preserve and restore sight.

How do I submit my application?

Applications and supporting documents may be submitted in person, by mail, fax, or email *(heaf@houstoneye.com).*

What happens next with my application?

It may take 3-6 weeks to process your application. Incomplete applications will take longer to process.

Surgical/ Medical Program

Once approved, you will receive a call to set an appointment with your doctor. An approval letter and service card will be sent you by mail and will be valid for one year. Patients are eligible for renewal at the close of the service year.

Eye Care for Kids Vision Program

Once approved, you will receive a call with your doctor's name and provided with an approved voucher. The doctor's office will also be notified of the applicant approval. The parent/guardian must set appointment and keep assigned doctor.

What services do you provide?

The Houston Eye Associates Foundation provides vision care services at no-cost to low-income, under-insured residents.

Surgical/Medical Program

Our physicians perform routine eye exams and are specialty trained in areas such as: cornea, retina, glaucoma, pediatrics, oculoplastic, and uveitis. Houston Eye Associates also has an optical center that specializes in vison correction. While Surgical/ Medical Program Foundation patients are accepted into the program throughout Texas, treatment is provided within the Greater Houston area. Currently, available services are limited to out-patient surgeries. Transportation and housing during care is to be arranged by the patient or their parent/guardian.

Eye Care for Kids Program

We partner with area optometrists who provide free eye exams and glasses to Foundation-referred, students in the area. With approval, the Foundation may underwrite a one-time replacement for broken or lost glasses.

Why do you need so many documents?

As a nonprofit organization, services at Houston Eye Associates Foundation helps meet the medical needs of low-income, under-insured Texans and those that cannot afford private care. The only way we can verify this information is by receiving copies of requested documents. Houston Eye Associates Foundation is audited each year and is required to provide documentation that demonstrates adherence to program acceptance guidelines.

What happens if my information changes (insurance status, contact information, household income)?

Please keep our office informed of all changes such as insurance, phone number, income, etc.

What is considered household income?

Household income is a measure of the combined support of all immediate family members sharing a place of residence. It includes all income including wages, retirement income, food stamps, Social Security, or Disability.

What do I do if I need help completing an application?

Please call us at 713-558-8740 and a staff member can assist you. Please come prepared with the documents listed on the check list, incomplete applications will be held until all required documents have been received. If needed, the Foundation has bilingual (Spanish/English) staff that can assist you.

How long will my application stay current?

Approved patients remain active in the programs for one year or until insurance/income status changes. They are eligible for renewal at the close of the year. Pending applications are retained for two years. Additional information may be requested.

Where is Houston Eye Associates Foundation located?

The Foundation Office is located at: **7155 Old Katy Road, Suite S110 Houston, Texas 77024**.
Patient care takes place at Houston Eye Associates locations, doctors' offices, or surgical centers in the Houston area.

TELEPHONE: 713-558-8740

FAX: 713-558-8760

EMAIL: heaf@houstoneye.com

SAMPLE LETTER OF FINANCIAL SUPPORT

A letter of attesting to financial support is required if surgical/medical patient applicant is over the age of 18 years and is being financially supported by someone they know.
Please submit with application and required documents.

I, _____, provide _____ with financial support.
name of individual *applicant name*

My relationship with the patient is _____.

I have been supporting them for _____.
length of time

The cost of this support is $_____ per ☐ week ☐ month ☐ year

The applicant resides with me: YES ☐ NO ☐

The support I give helps them with _____.

I receive income from _____.

Sincerely,

Sender's Name: _____

Sender's Signature: _____

Phone Number: _____

Consent to and Authorization of use and disclosure of Photos, Video, and Case History ("Material")

Houston Eye Associates Foundation relies on community support and partnerships to remove the economic barriers to vision care and treatment. Photos, documentation, publicity, advertising, and marketing help to secure this support and partnerships. Your agreement to use images and information will help with these efforts.

I hereby agree to be photographed and/or have my image/my child's image to be recorded by other means by Houston Eye Associates (HEA) and Houston Eye Associates Foundation (HEAF) to assist with my treatment, patient education, and for medical record documentation purposes. I understand that the taking and use of the photographic images are integral parts of cosmetic and reconstructive medical services. I understand that such photographic or recording (my "information") will be stored confidentially and may be disclosed consistent with the authorizations granted in this consent. In addition to these purposes, I hereby authorize and consent to HEA and HEAF using the images and medical history for the purpose of:

- ☐ YES ☐ NO News, publicity, advertising, marketing (including but not limited to print and internet publications). I agree to the distribution and publication of photographs, and other recordings via print and electronic means, including, but not limited to, HEA and/or HEAF's website, publications, and other Permitted Uses.
- ☐ YES ☐ NO Medical education (including but not limited to conferences, graduate medical education, and continuing medical education).
- ☐ YES ☐ NO Medical publications and professional trade organizations (including, but not limited to use in examination, testing, credentialing, and/or certifying purposes). I grant permission for any such photographs to be edited and incorporated into any compilation or derivative work as deemed necessary or appropriate by HEA and/or HEAF. I waive any right to inspect or approve my depictions in these works.

Each box checked ("Yes") is permitted use under this agreement ("Permitted Uses")

Please note that once information has been publicly shared on the internet it may appear in search results or be further used or disclosed by third parties without your permission.

I understand that this release and consent is voluntary and that I will receive no compensation for the use and disclosure of my information or likeness for HEA's or HEAF's internal, promotional, and advertising purposes. I further understand that I will have no economic or ownership rights in the interviews, photographs, and other recordings authorized above. I understand that it will be necessary for me to execute HEA's and/or HEAF's "HIPPA AUTHORIZATION FOR PERMITED USES" in order to allow HEA and/or HEAF to use my protected health information in connection with this Consent and Release for Photos. I UNDERSTAND THAT I MAY REVOKE MY CONSENT AT ANY TIME BY NOTIFYING HEA AND HEAF IN WRITING. I understand that my revocation will affect any actions HEA/HEAF took pursuant to this Consent and Release for Photos, Media, and Promotional Materials before HEA/HEAF received my revocation.

I hereby release HEA/HEAF as well and HEA/HEAF representatives and affiliates from any and all claims, liability, and damages that might arise from the use and disclosure of my name/my child's name, photograph, information, or likeness consistent with the authorization granted herein.

Note: A copy of this completed, signed, and dated form must be provided to the patient or the patient's representative/parent/guardian.

_____ PATIENT NAME PRINTED

_____ PATIENT DATE OF BIRTH

_____ PATIENT PARENT/GUARDIAN NAME

_____ MEDICAL RECORD NUMBER

_____ PATIENT SIGNATURE

_____ DATE

_____ PATIENT PARENT/GUARDIAN SIGNATURE

_____ WITNESS SIGNATURE

_____ WITNESS PRINTED NAME

_____ DATE