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, vision care for Texans in need.

Please complete and return with supporting documents by mail, email, fax, or in-person 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

EYE CARE FOR KIDS PROGRAM: ages 5-21

The **Eye Care for Kids Vision Program** provides free eye care to low-income, uninsured students in the Greater Houston area. This is a program through Houston Eye Associates Foundation. This care includes vision screenings, eye exams, and glasses at no cost to the patient. **Our foundation may be able to assist you if you do not qualify for vision coverage through CHIP, Medicaid, or private insurance.**

STUDENT INFORMATION

Does the student live in Texas permanently?	☐ Yes ☐ No	County	
Student name (first, MI, last)			
Student date of birth		Current age	
School District		School		Grade	
Does the student currently wear glasses?	☐ Yes ☐ No	Date of last eye exam	
Has the student had a vision screening at school, a community event, or a well-child visit?	☐ Yes ☐ No		
If so, where?			
Is the student a current Houston Eye Associates patient?	☐ Yes ☐ No		
Has the student applied to the HEA Foundation in the past?	☐ Yes ☐ No		
How did the student/parent/caregiver hear about the program?			

To be completed by school nurse

Visual Accuity	Aided RE	20/	Aided LE	20/
	Unaided RE	20/	Unaided LE	20/

OPTIONAL STUDENT DEMOGRAPHIC INFORMATION

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

Gender	☐ Male ☐ Female ☐ Other	Preferred language	Race/ Ethnicity (check all that apply)	○ Asian / Indian / Middle Eastern ○ Black / African American ○ American Indian / Alaskan Native ○ Native Hawaiian / Pacific Islander ○ White / Caucasian ○ Hispanic ○ Other
Pronouns	☐ He/ him ☐ She/ hers ☐ Other			

PARENT/GUARDIAN INFORMATION

First Name		Middle Initial		Last Name	
Street Address					
City		Zip Code		Email	
Mobile Phone		Okay to Text (messaging rates apply)?	☐ Yes ☐ No		
Alternate Phone Number:					

REQUIRED APPLICATION INFORMATION

☐ Yes ☐ No	Does the student have private health insurance?
	Insurance Plan Name
☐ Yes ☐ No	Does the student have any insurance through a government program?
	If yes, what program? ☐ Medicaid ☐ CHIP ☐ STAR Kids/Health/+PLUS ☐ Other
	If no, has the applicant applied for it? ☐ Yes ☐ No
☐ Yes ☐ No	Is anyone in the student's household employed?
☐ Yes ☐ No	Does the household file income taxes?
☐ Yes ☐ No	Does the student's household have other support (assistance from family or friends, savings, 401K, and/or retirement funds?
	If yes, please describe:

REQUIRED APPLICANT HOUSEHOLD INFORMATION

Total # of household members		Total # of household wage earners	
Approximate total household income	$ per year		

Name of each household member*	Applicant Relationship	Age	Employed	Monthly Income	Employer/ Income Source
1.	(self)		☐ Yes ☐ No	$	
2.			☐ Yes ☐ No	$	
3.			☐ Yes ☐ No	$	
4.			☐ Yes ☐ No	$	
5.			☐ Yes ☐ No	$	
6.			☐ Yes ☐ No	$	

** If more space is required, please 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 reason:

Please list and describe your monthly expenses:

Rent/Mortgage/Housing	Utilities	Food	Insurance (home, health, auto, etc…)	Auto	Other (please describe)
$					

REQUIRED CERTIFICATION

HEAF adheres to the **Federal Poverty Guidelines** set by the **U.S. Government** for the present year to assess eligibility. **THIS IS NOT HEALTH INSURANCE.**
HEAF reserves the right to verify and determine the validity of all documents presented with application.
Falsification of any information and/or documentation will disqualify you from receiving any services under the HEAF program.
(For more information regarding the U.S. Federal Poverty Guidelines please visit: https://aspe.hhs.gov/topics/poverty-economic-mobility/poverty-guidelines)

I understand that if I qualify, my status as a HEAF patient may be IMMEDIATELY revoked for failure to disclose all financial assets, or if HEAF becomes aware of undisclosed financial support while receiving HEAF 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**			
Printed Name		Date	
Relationship of person completing the application	☐ Parent/guardian *or* ☐ Authorized Individual		

AUTHORIZATION TO DISCLOSE INFORMATION

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

Name	Relationship	Phone number

HELP IS ALWAYS AVAILABLE!

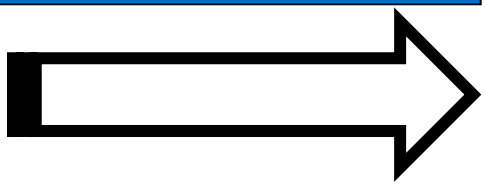
Please contact our office at

713-558-8740 or

heaf@houstoneye.com

for any questions or assistance with applications

APPLICATION CONTINUES ON NEXT PAGE



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 (HEAF) to cover ambulatory care and surgical facility fees, glasses, and other ancillary expenses for patients.

Initials	**I agree to the following terms or I may be terminated from the program:**
	1. **I understand that the Houston Eye Associates Foundation (HEAF) can only help me with services that:** **a. Are considered medically necessary by my doctor,** and **b. Fit within what HEAF is allowed to do.** If I need a doctor or specialist that HEAF does not work with, I will have to pay for those services myself. This also includes some tests or procedures that HEAF cannot pay for or provide.
not applicable for ECFK	2. **I understand that the Houston Eye Associates Foundation (HEAF) only helps with surgeries done in an Ambulatory Surgery Center (ASC)**. If my surgery must be done in a hospital instead, HEAF cannot help pay for it unless they clearly say they will. I will have to pay for any hospital-based procedures myself.
	3. **I will arrive on time for appointments**. I know the doctors are volunteering their time to help me. I will be respectful to the doctors, their staff, and their time. I know they also have other patients and busy schedules in their regular medical practice.
	4. **I will try my best to avoid cancellations**. If I cannot go to my appointment for any reason, I will call my doctor's office at least 24 hours before to cancel or reschedule.
	5. **I understand that HEAF keeps track of missed appointments.** If I miss too many appointments without calling ahead, I may be removed from the program.
	6. **I will follow my doctor's instructions.** This includes going to all required appointments and completing the full treatment plan while I am receiving help from them.
	7. **I understand that I must pay for my own transportation and lodging, if needed.** I understand HEAF will help cover my eye care services, but I am responsible for getting to and from my appointments. If I travel from out of town and need to stay overnight, I must arrange and pay for my own place to stay.
	8. **I understand that I must share all information about my income and financial resources.** HEAF may check this information to make sure it is correct, including my yearly income and how many people are in my family.
	9. **I must tell HEAF if my insurance changes.** This includes getting any new coverage, especially a Marketplace plan. Sometimes patients have insurance through a doctor's office or pharmacy; I am responsible for telling HEAF at the time of application. HEAF checks my deductible to see if I qualify for help. I understand HEAF will not count my out-of-pocket maximum. I will tell HEAF if I qualify for CIHCP (County Indigent Health Care Program).

I have read, understand, and agree to adhere to the above statements. I understand if I fail to adhere to <u>any</u> of the above-mentioned agreements, my foundation status may be terminated.

Signature of patient *OR* parent/guardian			
Printed name of patient *OR* parent/guardian			
Date		Relationship to patient	☐ Self *or* ☐ Parent/guardian

FREQUENTLY ASKED QUESTIONS ABOUT HEAF EYE CARE FOR KIDS PROGRAM

Houston Eye Associates Foundation (HEAF) is a non-profit organization founded in 1981 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 treatments including: surgical facility fees, medications, glasses, and ancillary services to preserve and restore sight.

Our **Eye Care for Kids Vision program** provides free vision care to low-income, uninsured students in the Greater Houston area. This care includes eye exams and glasses at no cost to the patient. The Foundation also provides free vision screening assistance for schools that are primarily in low-income, high-need communities.

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?

Application may take 1-2 weeks to process. Incomplete applications will require additional time for processing. Once approved, our office will notify you that your child has been eligible to receive services through our Kids Vision Program. You will receive an approval letter in the mail with the assigned optometrist near the child's home or school. Once the letter is received, the parent/guardian must schedule the appointment with the optometrist listed on the approval letter. Be sure to bring the approval letter to the appointment**. Approval letters are valid for one year.**

What services do you provide?

The Houston Eye Associates Foundation provides vision care services at no-cost to low-income, under-insured students in the Greater Houston Area who are 21 years old and younger.

Why do you need so many documents?

As a nonprofit organization, services at HEAF 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. HEAF 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)?

It is required to keep our office informed of all changes such as insurance, phone number, income, etc.

What is considered household income?

Household income includes the total financial support from all individuals living under one roof. This includes the applicant, spouse/partner, dependents (regardless of age), and anyone else for whom the applicant or spouse/partner bears legal responsibility.

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 checklist, 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 unless otherwise noted.
Applicants are eligible for renewal at the close of the year. Pending applications are retained for two years.

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 and participating clinics in the Houston area.

TELEPHONE: 713-558-8740
FAX: 713-558-8760
EMAIL: heaf@houstoneye.com

Sonji Mims
Program Services Coordinator
Direct: 713-668-6828 extension 2951
Email: smims@houstoneye.com

LETTER OF FINANCIAL SUPPORT

The following letter can be used for applicants who are over the age of 18 years and are being financially supported by someone they know. Please submit, if applicable, with application and required documents.

I, _____, provide _____ with financial support.
name of individual providing support *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 _____.
(ie: housing, utilities food, gas, clothing, etc…)

I receive income from _____.

Sincerely,

Sender's Name: _____

Sender's Signature: _____

Phone Number: _____

Date: _____