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

SURGICAL / MEDICAL SPECIALITY PROGRAM

Please describe eye health concern(s) applicant is experiencing: (example: cataracts, glaucoma, retina etc.)			
Date of last eye exam		Where?	
Is the applicant diabetic?	☐ Yes ☐ No		
Does applicant live in Texas permanently?	☐ Yes ☐ No	County	
Address		City	Zip Code
Is the applicant a current Houston Eye Associates patient?	☐ Yes ☐ No		
Has the applicant applied to the HEA Foundation in the past?	☐ Yes ☐ No		
How did the applicant hear about the program?			

REQUIRED APPLICANT INFORMATION

First Name		Middle Initial		Last Name	
Date of Birth		Age			
If applicant is under 18 years old, include Parent/Guardian name:					
Relationship to applicant under 18 years old:					
Mobile Phone		Okay to Text (messaging rates apply)?	☐ Yes ☐ No		
Alternate Phone		Email			

☐ Yes ☐ No	Does the applicant have health insurance?
	Insurance Plan Name
☐ Yes ☐ No	Does the applicant have any health insurance through a government program?
	If yes, what program? ☐ Medicaid ☐ Medicare ☐ Other
	If no, has the applicant applied for it? ☐ Yes ☐ No
☐ Yes ☐ No	Does the applicant have county medical assistance (County Indigent Health Care Program)?
	If no, has the applicant applied previously? ☐ Yes ☐ No
☐ Yes ☐ No	Is the applicant employed?
	If no, is unemployment due to vision issues? ☐ Yes ☐ No
☐ Yes ☐ No	Does the applicant's household file income taxes?
☐ Yes ☐ No	Does the applicant 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)
$					

OPTIONAL 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			

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(s) to disclose the above-named applicant's information:

Name	Relationship	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 (CIHCP)**

Applicants must have applied & shown proof of currently denied county medical assistance from their county of residence.
Below is a contact list of the most requested counties.
For a complete list of all CIHCPs, call **512-438-2350**
or visit: https://www.hhs.texas.gov/services/health/county-indigent-health-care-program.

To locate a local office, visit 211Texas.org or call 2-1-1 .

County	Program Name	Phone Number
Harris	Harris Health Financial Assistance Program (Gold Card)	(713) 566-6509
Fort Bend	County Indigent Health Care Program (CIHCP)	(281) 341-6624
Montgomery	Health Care Assistance Program (HCAP)	(936) 523-5100
Brazoria	County Indigent Health Care Program (CIHCP) Angleton Office: Alvin Office:	(979) 864-1884 (281)585-3024
Galveston	County Indigent Health Care Program (CIHCP)	(409) 949-3439
Jefferson	County Indigent Health Care Program (CIHCP) Beaumont Office: Port Arthur Office:	(409) 835-8530 (409) 983-8380
Dallas	Parkland Financial Assistance (PFA)	(214) 590-8831
Collin	County Indigent Health Care Program (CIHCP)	(972) 548-4702
Travis	Medical Access Program (MAP)	(512) 978-8130
Bexar	CareLink Program	(210) 358-3350
Matagorda	Medical Assistance Program (M.A.P.)	(979) 245-8421

☐ **REQUIRED** **Proof of Household Income**

- **To complete your application, please provide income details for ALL household members living under one roof, including:**

  • Applicant • Spouse/partner • Dependents (regardless of age)
  • Anyone else under the legal responsibility of applicant or spouse/partner

PLEASE SUBMIT THE FOLLOWING DOCUMENTATION(S) BASED ON SITUATION:

- If **employed**, minimum of THREE (**3**) or more recent Paystubs / Pay Statements
  - If receiving cash, an employer letter on official letterhead stating monthly pay will suffice
- If **self-employed**, include a letter confirming occupation, gross monthly income, AND/OR three (3) months of bank statements
- If receiving **governmental or private benefits**, please submit most recent Benefit Award Letter.
  Example: Social Security, Disability, Retirement, Unemployment, Pension, Survivors.*
  **SSI Disability recipients must also provide the start date of benefits.*
- If **unemployed and living independently**, provide a support confirmation letter (*See Sample at the end of this application*).
- If **unemployed and relying on savings/retirement**, please provide bank statements for the last three (3) months.
- If **living in a group home or shelter**, include a residence confirmation letter on agency letterhead.

- **Applicants must provide a copy of most recent household Tax Return(s) for each filing household member.**

REQUIRED APPLICATION SUPPORT CHECKLIST: SURGICAL/ MEDICAL PROGRAM (continued)

☐ **REQUIRED** **Proof of Identification**

Applicant must provide a copy of photo ID

EXAMPLE: Driver's License, State ID, Matricula Consular, Legal Permanent Resident Card, Employment Authorization Card, Passport, and/or Visa.

☐ **REQUIRED** **Denial from Medicare or Medicaid**

- **For applicants over 65 years of age,** a denial letter from **Medicare** must be included with this application.

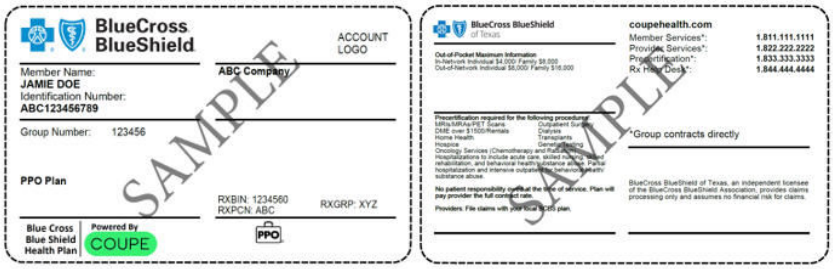
  Online: Visit the official Medicare website (medicare.gov) and follow the instructions to apply online.
  By Phone: Call Social Security at 1-800-772-1213 (TTY 1-800-325-0778) to apply over the phone.
  In Person: Visit your local Social Security office to apply in person

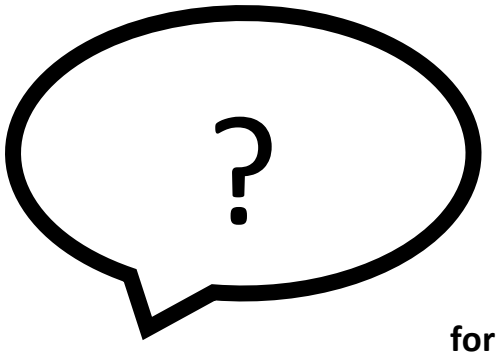
- **For applicants under 18 years of age,** denial letter from **Medicaid** must be included with this application.

  Online: Visit the Texas Health and Human Services Commission (HHSC) website (hhs.texas.gov). Use the yourtexasbenefits.com portal to create an account and log in.
  By Phone: Call the Texas Medicaid hotline at 2-1-1 or 1-877-541-7905 to apply over the phone
  By Mail: Download the Medicaid application form from the HHSC website or request a paper application by calling. Mail the completed application form along with required documents to address provided on form or HHSC website.
  In Person: Visit a local HHSC office or a Community Partner organization.
  Find the nearest HHSC office or Community Partner by using the HHSC office locator tool on their website.

☐ **REQUIRED** **Proof of Insurance**

ONLY IF the applicant has private medical insurance, please include a copy of the insurance plan detailing plan benefits and provide a copy of the insurance card, both front and back (*see example*).





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.
	2. **I understand that the Houston Eye Associates Foundation (HEAF) only helps with surgeries done in an Ambulatory Surgery Center (ASC**). 3. 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.
	4. **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.
	5. **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.
	6. **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.
	7. **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.
	8. **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.
	9. **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.
	10. **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 MEDICAL/SURGICAL 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.

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 3-6 weeks to process. Incomplete applications will require additional time for processing.
To expedite the process, please contact our office after submitting your paperwork rather than waiting for us to initiate contact.
Once approved, you will receive a call with your appointment details.
Additionally, an approval letter and Foundation ID card will be mailed to you.
These documents will **be valid for one year unless otherwise specified**.
Patients are eligible for renewal at the end of the service year.

What services do you provide?

HEAF provides vision care services at no-cost to low-income, under-insured residents.
Our physicians perform comprehensive eye exams and are specialty-trained in many ophthalmology areas.
Houston Eye Associates also has several on-site Optical centers that specialize in vision correction.
While patients are accepted into the program throughout Texas,
treatment is provided only at our facilities within the Greater Houston area.
Currently, available services are limited to outpatient surgeries.
Transportation & housing during care are to be arranged by the patient, their parent/guardian, and/or authorized representative.

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, doctors' offices, or surgical centers in the Houston area.

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

Ashley Herrera
Program Services Coordinator
Direct: 713-668-6828 extension 2447
Email: aherrera@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** ☐ **other:**

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: _____