EYE CONSULTANTS OF ATLANTA
OPERATION SAVING SIGHT APPLICATION

_____ _____ _____
Applicant's Name DOB Social Security

_____ _____
Home Phone Mobile Phone

_____ _____ _____ _____
Street Address City State Zip Code

EYE CARE SERVICES OR PROCEDURES REQUESTED

What is your current eye problem? Please include a copy of your doctor's findings or have notes faxed to our office. (404-351-7070). List other medical conditions: _____

_____

Patient must be available for at least 60 days after surgery for postoperative care.

HOUSEHOLD INFORMATION
(Please list your spouse, children, parents, or other dependents)

Housing status ☐ Rent Other_____

☐ Own

☐ Staying with someone

First & Last Name _____ Relation to patient_____ Age _____ Employment Status ☐ Employed ☐ Not Employed ☐ N/A

First & Last Name _____ Relation to patient _____ Age _____ Employment Status ☐ Employed ☐ Not Employed ☐ N/A

First & Last Name _____ Relation to patient_____ Age _____ Employment Status ☐ Employed ☐ Not Employed ☐ N/A

First & Last Name _____ Relation to patient_____ Age _____ Employment Status ☐ Employed ☐ Not Employed ☐ N/A

HOUSEHOLD INCOME AND EMPLOYMENT INFORMATION

1) Patient:

Name: _____

Employer: _____
Wages/Tips (Before Taxes)

$ _____

☐ Hourly
☐ Weekly
☐ Bi-Weekly
☐ Monthly
☐ Yearly

Occupation _____

Average hours worked per week _____

OTHER INCOME

Unemployment: $ _____ /week

Social Security: $ _____ /month

Supplemental Security Income (SSI): $ _____ /month

Pension/Retirement: $ _____ /month

Child or Spousal Support: $ _____ /month

Other: $ _____

2) Additional Wage Earner

Name: _____

Employer: _____

Wages/Tips (Before Taxes)

$ _____

☐ Hourly
☐ Weekly
☐ Bi-Weekly
☐ Monthly
☐ Yearly

Occupation _____

Average hours worked per week_____

OTHER INCOME

Unemployment: $ _____ /week

Social Security: $ _____ /month

Supplemental Security Income (SSI): $ _____ /month

Pension/Retirement: $ _____ /month

Child or Spousal Support: $ _____ /month

Other: $_____/month

PATIENT INSURANCE INFORMATION

Does patient have insurance? ☐ Yes ☐ No

If no, have they applied for state medical assistance? ☐ Yes ☐ No

Reason for ineligibility (if applicable)_____ (Please provide copy of denial)

If patient has insurance list plan name: _____ Policy Number: _____ Group Number _____

HOUSEHOLD MONTHLY BILLS/OBLIGATIONS

Please list all of your monthly bills or payment arrangement obligations for patient and household. These may include but are not limited to: mortgage/rent, utilities (gas, electrical, water), cable, phone service, internet, car payments and insurances, credit card balances & monthly payments, medical bills, medications, child or spousal support etc.

Type of Bill/Obligation	**Monthly $ Amount**	**Is patient directly responsible for full/partial payment?**	
MORTGAGE/RENT	_____	☐ Yes ☐ No	$_____ if partial
UTILITY - GAS	_____	☐ Yes ☐ No	$_____ if partial
UTILITY – ELECTRIC	_____	☐ Yes ☐ No	$_____ if partial
UTILITY – GARBAGE	_____	☐ Yes ☐ No	$_____ if partial
UTILITY – WATER/SEWER	_____	☐ Yes ☐ No	$_____ if partial
PHONE – CELL/OTHER	_____	☐ Yes ☐ No	$_____ if partial
CABLE/INTERNET	_____	☐ Yes ☐ No	$_____ if partial
CAR PAYMENT	_____	☐ Yes ☐ No	$_____ if partial
MEDICAL BILLS-PATIENT	_____	☐ Yes ☐ No	$_____ if partial
MEDICAL BILLS-OTHER MEMBERS	_____	☐ Yes ☐ No	$_____ if partial

MEDICATIONS-PATIENT _____	☐ Yes ☐ No	$_____	if partial
MEDICATIONS-OTHER MEMBERS _____	☐ Yes ☐ No	$_____	if partial
CREDIT CARD DEBIT _____	☐ Yes ☐ No	$_____	if partial
OTHER _____	☐ Yes ☐ No	$_____	if partial
OTHER _____	☐ Yes ☐ No	$_____	if partial

INCOME DOCUMENTATION IS REQUIRED. PLEASE INCLUDE MOST RECENT TAX FILING, ANY GOVERNMENT ASSISTANCE, AND/OR MONTHLY PAYMENTS YOU RECIEVE.

EXTENUATING CIRCUMSTANCES IMPACTING YOUR FINANCIAL STATUS/SUMMARY OF WHY YOU FEEL YOU SHOULD BE CONSIDERED A CANDIDATE FOR FREE EYE SURGERY:

_____

_____

_____

_____

_____

I declare that all parts of this application are true and correct statements, to the best of my knowledge. I understand an incomplete application may result a denied eligibility. I understand that the details of this application are solely used to determine my overall financial status and possible eligibility for Operation Saving Sight.

_____ _____

Patient Signature Date

PLEASE SEND COMPLETED FORM TO:

Eye Consultants of Atlanta
Stephanie at Operation SavingSight
3225 Cumberland Blvd, SE, Suite 900
Atlanta, GA
30339