Center for Visual Surgical Excellence

A US EYE COMPANY

FREE CATARACT SURGERY APPLICATION

Please complete the following information and attach the required financial documentation to be considered for the program. For questions regarding the application, please call 941-493-2020.

Applicant Name: _____
Last Name First Name Middle Initial

Social Security Number: _____ Date of Birth: _____

Gender: ☐ Male ☐ Female Preferred Language*: _____

Phone Number: _____ Alternate Phone Number: _____

E-Mail Address: _____

Address: _____
Street Address

_____
City State Zip Code

I am: ☐ U.S. Citizen ☐ Resident Alien (Green Card) ☐ Other: _____

Marital Status: ☐ Divorced ☐ Married ☐ Separated ☐ Single ☐ Widowed

I am: ☐ Homeowner ☐ Renter ☐ Boarder ☐ Homeless

Total number of people in my family / household: _____ Please list names and relationships below.

If you need additional space for household members, please attach a separate list. ☐ See attached list.

_____ ☐ Spouse ☐ Child ☐ Parent ☐ Roommate ☐ Other: _____

_____ ☐ Spouse ☐ Child ☐ Parent ☐ Roommate ☐ Other: _____

_____ ☐ Spouse ☐ Child ☐ Parent ☐ Roommate ☐ Other: _____

I am: ☐ Employed - Full Time ☐ Employed - Part Time ☐ Retired ☐ Unemployed

If employed, what is your place of employment? _____

If unemployed or retired, what was your occupation? _____

I have: ☐ No Insurance ☐ Medicare ☐ Medicaid ☐ Other Insurance: _____

How did you hear about the program? _____

If referred by a physician, what is the physician's name? _____

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Monthly Household Income

What is your monthly income? _____

What is your spouse's monthly income? _____

What is the monthly income of others in your home; not including roommates? _____

Do you receive social security disability? If so, how much? _____

Do you receive a retirement pension? If so, how much? _____

Do you receive any government assistance (i.e., food stamps)? If so, how much? _____

Do you have rental income from real estate? If so, how much? _____

Do you receive any other income from any other source? If so, how much? _____

Do you receive any financial assistance from friends or family? If so, how much? _____

Total Monthly Income _____

Monthly Household Expenses

Rental or Mortgage Payment _____

Food (groceries and restaurants) _____

Clothing _____

Transportation (i.e., car, public, friends, etc.) _____

Utilities (i.e., electric, water, etc.) _____

Medical Expenses including Prescriptions _____

Misc. Expenses (i.e., pet care, loan debt, etc.) _____

Total Monthly Expenses _____

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Have you been diagnosed with cataracts by a physician? ☐ Yes ☐ No

Have you been diagnosed with any other eye conditions or diseases? ☐ Yes ☐ No

If Yes, please explain. _____

Do you wear glasses or contact lenses? ☐ Yes ☐ No

When was your last eye exam? _____

What is the name of the physician that performed your eye exam? _____

How bad is your vision today? What do you have the most difficulty seeing or doing?

_____

_____

_____

_____

When did you first realize that you were having difficulty seeing?

_____

_____

_____

_____

How is your poor vision affecting your quality of life? (i.e., work, hobbies, etc.)

_____

_____

_____

_____

Do you use any visual aides to assist you in your daily routine? ☐ Yes ☐ No

If Yes, please explain. _____

_____

_____

What are some of the things you are excited to do when your vision is restored, and you can see better again?

_____

_____

_____

_____

How do you feel about Center for Visual Surgical Excellence donating free cataract surgery?

_____

_____

_____

_____

Would you be willing to share your story to help raise awareness about the program? ☐ Yes ☐ No

I have attached the following financial support documentation with my application.

- ☐ Federal tax return
- ☐ Documentation to support that no Federal tax return was required due to lack of income
- ☐ W2(s) and / or 1099(s) income statements
- ☐ Social Security retirement or disability income statement (SSA1099)
- ☐ Qualifying documentation for food stamps
- ☐ Other: _____

Reminder: Financial documentation **must** be included with your application in order to be considered for free cataract surgery.

I confirm that the information provided is complete and accurate to the best of my knowledge.

***If English is not my primary language, I certify that I will bring a translator with me to all visits including my surgical appointments.**

Signature: _____ Date: _____