

HOUSTON EYE ASSOCIATES FOUNDATION

2855 Gramercy

Houston, Texas 77025

For More Information: Phone 832-553-7114 or 713-558-8760 Fax 713-668-3823

ABOUT THE FOUNDATION

Houston Eye Associates Foundation provides EYE SURGERY for *those who qualify*.

The Houston Eye Associates Foundation is a non-profit organization formed in 1981 by a group of ophthalmologists to assist individuals in need of medical eye care. In addition, Houston Eye Associates Foundation pays for hospitalization and related medical eye care expenses for these patients. In some cases, office visits are offered at a reduced rate and surgeries are made available on payment plans.

WHO TO CALL IF YOU ONLY NEED GLASSES

For children in need of glasses: call The Lion's Club at (713) 796-2960 or Prevent Blindness at (713) 526-2559. Adults needing glasses should contact the University of Houston Good Neighbor Clinic at (713) 527-8480. This clinic provides low-cost eye exams and discounted glasses.

WHO QUALIFIES: *To qualify for H.E.A. Foundation assistance, the following conditions must be met:*

- a) You do not have medical insurance and cannot afford medical healthcare.
- b) All children in Texas age 18 & under, are eligible for affordable insurance through a program called the TexCare Partnership/CHIP. To apply call 1-800-647-6558, or go online: Texcarepartnership.com
- c) You have applied, and can show proof that you've been **denied** government medical assistance such as **Medicare/Medicaid**.
To find out if you are eligible for **Medicare**, call **1-800-772-1213**.
To find out if you are eligible for **Medicaid**, call **1-800-252-8263**.
- d) You have applied and can show proof that you have been **denied county medical assistance** in your county.
Harris County provides medical assistance to its residents through the Gold Card program.

If you live in one of the following counties please call the phone number for your county to apply for assistance:

Harris County Gold Card- 713-740-8180

Chambers County- 409-267-8306

Galveston County- 409-763-7201

Ft. Bend County- 281-341-6624

Brazoria County- 979-864-1884

Montgomery County- 936-523-5100

HOW TO APPLY

If you meet the above criteria, please complete the other side of this form and return **it along with a copy of your most recent tax return and proof that you have been denied government and county medical assistance**. If you do not have a tax return, you will need to send proof of income, such as a W-2 or a handwritten letter from your employer. If you are unemployed and living with family members, please send proof of household income for the family with whom you are living.

HOUSTON EYE ASSOCIATES FOUNDATION APPLICATION

Please print clearly in ink and return with the required paperwork stated on the other side to:

2855 Gramercy

Houston, Texas 77025

Phone 832-553-7114 Fax 713-668-3823

Applicant's Name (last/first) _____ Date: _____

If you are a current patient of Houston Eye Associates, who is your physician? _____

For what type of medical eye problem are you seeking help? _____

Who referred you to Houston Eye Associates Foundation? _____

Name of Patient (last/first) _____ Name of Parent (If patient is under 18) _____

Birth Date _____ Social Security Number _____ (_____) _____ (_____) _____
Home Phone _____ Work Phone _____

Address _____
City _____ State _____ Zip _____

Total number of persons in household _____ Number of wage earners in household _____ Yearly household income _____

PLEASE ANSWER YES OR NO:

1. Do you have health insurance? _____
2. Do you have Medicare? _____
3. Do you have Medicaid? _____ If NO, have you applied for it? _____
4. Do you have a Harris County Gold Card? _____ If NO, have you applied for one? _____
5. Do you receive medical assistance from another county? _____ If NO, have you applied for assistance? _____
8. Do you receive social security or disability? _____ If YES, how much? _____
9. Do you receive child support? _____ If YES, how much? _____

IMPORTANT: IF YOU HAVE BEEN DENIED MEDICARE/ MEDICAID, A HARRIS COUNTY GOLD CARD OR YOUR COUNTY'S MEDICAL ASSISTANCE PROGRAM, YOU MUST ATTACH LETTER (S) OF DENIAL TO THIS APPLICATION AS WELL AS A COPY OF YOUR HOUSEHOLD INCOME TAX RETURN

Your Employer _____ Position _____ Yearly gross income _____

Spouse's Employer (If applicable) _____ Position _____ Yearly gross income _____

Please list the amount of your monthly expenses: Rent/Mortgage _____ Electricity _____

Telephone _____ Food _____ Car _____ Child Support (if applicable) _____

Sign here stating the information you have provided above is true: _____