



# Vision Surgery Services Application



**This application is ONLY for The Lighthouse vision surgery services. Eyeglasses and hearing aids have separate applications. Do not complete this application unless you are seeking vision surgery assistance.**

The Lighthouse is a non-profit 501 (c) (3) non-governmental organization. Our mission is to provide vision and hearing services with dignity and respect to uninsured, low-income people in Georgia. The services we provide are made possible by donations and support from individuals, foundations, and the business community. **We are not a free clinic.** Service eligibility is based on income. **The Lighthouse vision surgery service provides assistance for cataract, glaucoma, and diabetes related vision loss only.**

**\*\*\*\*\*ATTENTION\*\*\*\*\***

If you are a resident of DeKalb or Fulton counties, you will not be eligible for assistance through The Lighthouse, and there is no need to complete this application. You may seek services from Grady Memorial Hospital.

If you currently have or qualify for Medicare/Medicaid, Affordable Care Act (Obama Care), private insurance or Veteran's Benefits, there is no need to complete this application, as you **will not** qualify for our services.

**PLEASE READ ALL OF THE INFORMATION PROVIDED. IT WILL ANSWER MANY OF YOUR QUESTIONS AND ELIMINATE THE NEED TO CALL.**

**THE APPLICATION IS AT THE BACK OF THIS PACKET (PAGES 9 - 13).**

**PLEASE DETACH THESE PAGES AND SUBMIT APPLICATION WITH ALL REQUESTED DOCUMENTATION.**

If you are unable or unwilling to provide the documentation, your application will not be approved.

**Contact Information:**

Phone Number: 404-325-3630 FAX: (*Vision Surgery only*) 404-631-6441

Business hours: Monday- Friday 9:00 am – 5:00 pm

For more information, please visit our website at: [www.lighthousegeorgia.org](http://www.lighthousegeorgia.org)

*(April 2019 Revision)*

## General Information for Vision Surgery

Eligibility for our services is determined by the application process.

The Lighthouse will not pay for expenses incurred prior to the approval of an application by the Lighthouse Associate Director of Surgery.

If you are approved, you will be contacted by The Lighthouse office. The Lighthouse will coordinate your appointments with participating eye specialists.

***DO NOT SCHEDULE ANY EYE APPOINTMENT OR EYE SURGERY WITHOUT FIRST NOTIFYING THE LIGHTHOUSE!***

**Please note: The information and application in this packet is intended for Vision Surgery only. The documentation for surgery is extensive because we work with medical facilities and doctors that require specific information. If you are unable or unwilling to provide the documentation, your application will not be processed nor approved.**

**Payment and Fees:** We do not accept insurance of any kind! If you have insurance, you will not qualify for our services and must seek your surgery through other avenues. This means if you have Medicaid, Medicare, Affordable Care Act (Obama Care), private insurance, or Veteran's Benefits, you will not be eligible. Surgery assistance is limited to individuals who do not have nor qualify for Medicaid, Medicare, private insurance, or Veteran's Benefits.

Through the partnerships with volunteer eye doctors, all surgeries are performed in pre-approved facilities. Surgeries often exceed a cost of \$7,000.00, therefore the eligibility requirements must be strictly adhered to.

**You may be required to obtain documentation for approval or denial of indigent care/financial assistance at the facility in which the surgery will be performed. (Guidance and instruction will be provided on this process by the Associate Director of Surgery. However, no discussion can be held until application is received.)**

## Patient Rights and Responsibilities

### Civil Rights

1. Patients have the right to considerate and respectful treatment in an environment free from harm.
2. Patients seeking services shall not be denied, suspended or terminated from services or have services reduced for exercising any of their rights.

## **Discrimination**

1. Patients have the right to receive services regardless of age, sex, race, creed, color, religion, ethnic origin, ancestry, marital status, physical or mental disability, gender preference, veteran status or criminal record.
2. No recipient of services is presumed legally incompetent except as determined by a court.
3. Patients have the right to present any complaint or grievance on matters pertaining to services received, or any perceived or actual violation of rights.

## **Privacy/Confidentiality**

1. The Lighthouse understands the patient health information is personal and is dedicated to maintaining patient privacy rights under Federal and State law. All staff is trained in HIPAA compliance.
2. Patients will receive confidential treatment; all clinical records and client information are protected by law, regulations and center policies. For the purposes of funding, certification, licensure, audit, research or other legitimate purpose, your clinical record may be used by the person conducting the review to the extent that is necessary to accomplish the purpose of the review.
3. Patient information released to or requested from other sources requires your written consent. Patient records can be subpoenaed by court order and does not require your signature for release of information.
1. Patients have the right to review and obtain a copy of their clinical record upon request. Processing fees may be applied.

## **Electronic Health Records**

The Lighthouse utilizes an electronic health record system, to maintain patient information, contact doctors, and medical facilities. This helps to ensure patient and health care providers have access to accurate personal health information. Patients may call to inquire about their own appointments, statuses, and medical information during business hours.

## **The Lighthouse Responsibility**

1. In the case of suspected child abuse or neglect, The Lighthouse is required by the Abused and Neglected Child Reporting Act to report any suspected incidents of neglect or abuse. The Lighthouse also has the ethical obligation to report suspected maltreatment of senior citizens or adults.
2. If at any time patients present a clear and present danger to yourself or to others, Lighthouse staff may release information that is required to authorities in order to protect you and/or others.
3. The Lighthouse may restrict or terminate delivery of services to patients who have been evaluated and determined as posing a serious physical threat to staff or others.

## **Patient Responsibility**

1. Patients are expected to complete application and submit via FAX or mail (address and number are on application)
2. Patients are expected to provide accurate and complete information. If your address or phone number changes, please contact us to update your patient profile.
3. Patients are expected to provide accurate and complete information about their health and medical history, as listed on application.
4. Patients are expected to be considerate and treat all Lighthouse staff, volunteers, other patients, and visitors with courtesy and respect and be mindful of others privacy.
5. Communications between client and Lighthouse staff are confidential and will not be revealed unless required by law such as in situations of child abuse, elder abuse, and or threats of physical harm to self or others.

## **Patient Policies**

### **Appointments**

1. In the event of inclement weather (for your geographic area), please call the clinic or check local television stations for announcements regarding the canceling or delaying of your scheduled appointments. If your appointment has been changed, or cancelled by your doctor, please notify The Lighthouse.

### **Missed/Cancelled Appointment Policy**

1. If a patient is unable to keep a scheduled appointment, he/she must give a 24 hour cancellation notice directly to the eye doctor and to The Lighthouse. This may be done over the phone.
2. If a patient does not provide a 24 hour advance notice or cancellation, this will be considered a missed or no-show appointment.

### **Dismissal Policy**

Failure to adhere to Patient Policies may result in dismissal from the surgery program. You will no longer be able to utilize services at The Lighthouse.

In order to maintain safety, any patient who threatens employees, other patients, or compromises The Lighthouse mission may be dismissed from the facility. Behavior justifying dismissal includes but is not limited to that which is abusive or threatening toward self or others; violent in language, gestures or actions; any type of harassment; and chronic failure to keep appointments, or adhere to policies as outlined in this patient packet.



## Patient Eligibility

**The Lighthouse is not a free clinic.** We are able to provide these discounted surgeries because of the doctors who volunteer their time and skills to perform these services and because of medical facilities that are willing to partner with the doctor and The Lighthouse.

We serve **current** residents of Georgia that fall below the Federal Poverty Guidelines of 200% per household. Eligibility is determined by an application process. The application must be fully completed and include the required documentation. Failure to do so will only delay your process.

### Qualifications

To qualify for Lighthouse surgery services, you must:

- Be a Georgia resident for 12 months prior to date of application
- Meet our income requirements
- We do not accept insurance of any kind! If you have insurance, you will not qualify for our services and must seek your surgery through other avenues. Surgery assistance is limited to individuals who do not have or qualify for Medicaid, Medicare, private insurance, or Veteran's Benefits.

**NOTE! Individuals residing in Dekalb or Fulton counties will not qualify for our surgery services because those residents have access to the Grady Health System.**

The following is an explanation of the documentation required. The actual application is attached at the end of this packet. **Again, failure to submit the documentation will delay your application process! If complete documentation is not received within 3 months, your application will be considered null and void and you will have to begin the application process all over again.**

## **Required documents**

Proof of identification, residency and income are required to determine your eligibility. Patients must present, **ONE** Proof of Identification, **ONE** Proof of Residency and **TWO** Proof of Income. Please do not send in partial documents. Submit everything as a complete package with the application. If any of the documents are not included with your application, your request will not move forward.

### **Helpful points for documentation requirements:**

- We must see two months of income/salary----therefore, choices are provided to you to make this easier
- If married, you must provide paycheck stubs for each spouse. Or if you have a significant other, you must also provide paycheck stubs for that person.
- All Identification cards must be current, up-to-date, and legible. We will not accept any expired proof of identification. All identification should have a picture of you on it.
- Contact the IRS at 1-800-908-9946 to request a 4506-T Form for non-filing or filing transcript

## **SUPPORTING DOCUMENTATION EXPLAINED BELOW AND IS REQUIRED!!**



### **1) IDENTIFICATION: ALL IDENTIFICATION CARDS MUST BE CURRENT (NOT EXPIRED) AND CLEARLY SHOW YOUR PHOTO. (*Please choose 1*)**

- Unexpired Georgia driver license OR Georgia identification card
- School ID
- Consulate ID card
- Birth certificate (age 19 and under only)

### **2) RESIDENCY: (*Please choose 1*)**

- Copy of current rental agreement including signature page
- Copy of most recent Mortgage statement or Property tax statement
- Letter from shelter, transitional home, or nursing home stating that you live at that location (on letterhead and signed by shelter or transitional housing employee)

- Copy of most recent utility bill, including the name of the applicant and service address, from either the applicant or member of household (Utilities only include: gas, water, and electric)

**3) INCOME: (Please choose 2)** You must send two (2) of the items from this list below that **apply to you AND everyone in the household.**

- Last year's tax return
- Two (2) current consecutive paycheck stubs for bi-weekly pay; or 4 current consecutive paycheck stubs for weekly pay
- Current Social Security/Disability Award letter
- Current Food Stamp award letter from Department of Family and Children Services (DFACS)
- Letter from nursing home (on letterhead and signed by nursing home employee)
- Letter from shelter (on letterhead and signed by shelter employee)
- Regular payments from alimony, child support, unemployment, union funds, retirement/pension, or other government programs funds
- College/university scholarship, grant, fellowship, or assistantship

**You may be required to obtain documentation for approval or denial of indigent care/financial assistance at the facility in which the surgery will be performed. (Guidance and instruction will be provided on this process by the Associate Director of Surgery. However, no discussion can be held until application is received.)**

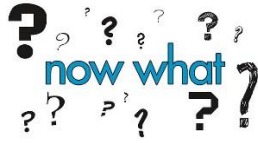
**Medical**

- Provide copy of most recent exam notes indicating your need for surgery
- Documentation verifying current Medicaid/Medicare denial is required for surgery applications, and must be dated within last 3 months.

**Before submitting application, please make yourself a copy.**

**\*\* We do not provide copies! \*\***

**All documentation that is submitted should be a copy—you should keep the original!**



## Approval Process

- Upon receipt of your application in our office, you will receive notice by mail within 3-4 weeks indicating approval or denial status. Detach application pages 9-13 to submit.
- If applicant's address changes, please notify our office so that your mailing profile can be updated. Otherwise, all correspondence will be mailed to address on original application.
- If complete documentation is not received within 3 months, your application will be considered null and void and you will have to begin the application process all over again.
- Applicants that are approved for services, must reapply every six months for additional surgeries based on available program funding.



**\*\*\*IMPORTANT! Final Reminder!\*\*\***

**Your application will not be processed without  
copies of ALL of your supporting  
documentation!!**

***We do not make copies for you!***





The Georgia Lions Lighthouse is a 501(c) (3) nonprofit. Our mission is to provide vision and hearing services through education, detection, prevention, and treatment. The services we provide are made possible by donations and support from individuals, foundations, and the

## **This application is for Vision Surgery only!**

### **QUALIFICATIONS**

To qualify for Lighthouse program services, you must:

- Be a Georgia resident for at least 12 months
- Meet our income requirements
- **Submit copies of ALL required documents.** If any of the documents are not included with your application, your request will not move forward.

### **APPROVAL PROCESS**

- You will receive notice of your qualification status **by mail within 3-4 weeks.** **If complete documentation is not received within 3 months, your application will be considered null and void and you will have to begin the application process all over again.**

business community.

**Once completed, send your application and copies of all required documents to us by mail, fax. If you have any questions, please call us at 404-325-3630.**

**NOTE: When faxing, remember to turn paper to correct side appropriate to fax device. (Each one is different). If you call to confirm receipt, you must have the fax number from which the fax was sent.**

#### **Mail**

The Lighthouse  
5582 Peachtree Road  
Chamblee, GA 30341

#### **Fax**

404-631-6441



# Vision Surgery Application

*(Please print clearly in blue or black ink)*

1. Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_ MI: \_\_\_\_\_

2. Address: \_\_\_\_\_

City: \_\_\_\_\_ State: Georgia Zip Code: \_\_\_\_\_

3. County of Residence: \_\_\_\_\_

4. Home Phone: \_\_\_\_\_ Mobile Phone: \_\_\_\_\_

5. Email Address: \_\_\_\_\_

6. Name of Parent or Guardian (if under 18): \_\_\_\_\_

7. Referred by: \_\_\_\_\_ Primary Care Provider: \_\_\_\_\_

8. Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_ Age: \_\_\_\_ 9. Gender: Male Female Other

10. Marital Status: Single Married Divorced Legally Separated Widowed

11. Last four digits of Social Security Number: \_\_\_\_ \_\_\_\_ \_\_\_\_ \_\_\_\_

12. Are you employed? Yes or No 13. Are you a Veteran Yes or No

14. If you are unemployed, please provide the reason:

Disabled (circle if you receive SSI/SSDI)  Not Able  Retired  Lost Job  Other

15. Race:  White, not Hispanic or Latino  Black or African American  Asian

American Indian or Alaskan Native  Native Hawaiian or Other Pacific Islander  Other Race

Two or more races  Decline to Specify

16. Ethnicity:  Hispanic or Latino  Not Hispanic or Latino  Decline to Specify

17. Please circle the type of insurance coverage you have:

Grady  Medicaid  Medicare  Veteran's Benefits  Private  None

18. Total Number of People in Household: \_\_\_\_\_

19. Do other adults live in your home? YES OR NO

20. Is there anyone other than yourself financially responsible for you? YES or NO  
 a. If you have answered yes, provide name of person \_\_\_\_\_ .  
 b. Does this person live in your home? YES or NO

21. List your name (applicant) and all individuals residing at your address. Indicate if the individuals listed are your dependents. (A dependent is someone you support financially).

22. Applicant's Name: \_\_\_\_\_ Amount of gross monthly income: \_\_\_\_\_  
 (Gross income is defined as: "All income from all sources before taxes")

23. List names of all individuals living in your home, including yourself: \_\_\_\_\_

- A.) \_\_\_\_\_ Amount of gross monthly income: \_\_\_\_\_  
 B.) \_\_\_\_\_ Amount of gross monthly income: \_\_\_\_\_  
 C.) \_\_\_\_\_ Amount of gross monthly income: \_\_\_\_\_  
 D.) \_\_\_\_\_ Amount of gross monthly income: \_\_\_\_\_  
 E.) \_\_\_\_\_ Amount of gross monthly income: \_\_\_\_\_

24. List type and total amount of gross monthly income received by you and all household members.

<u>Benefit</u>	<u>You</u>	<u>Person A</u>	<u>Person B</u>	<u>Person C</u>	<u>Person D</u>	<u>Person E</u>
Employment						
Supplemental Security income						
SSDI						
Social Security						
Food Stamps						
Welfare (AFDC)						
Veterans Benefits						
Pension/Retirement						
Child Support						
<b>TOTAL</b>						

25. Total Gross Monthly Household Income: \$ \_\_\_\_\_ (all members listed)

**\* ALL questions, statements, and information above must be completed in order for the application to be considered complete!!**

# Medical Information

1. Please check if you have or have had any of the following:

Glaucoma     Diabetes     Hypertension     Stroke     Cataracts

2. When did your vision problems begin?

Month: \_\_\_\_\_ Year: \_\_\_\_\_

3. When was your last eye exam? \_\_\_\_\_

4. Describe your eye condition:

a. Right eye: \_\_\_\_\_

b. Left eye: \_\_\_\_\_

5. Is your eye condition the result of an injury? Yes or No.

If yes, please explain: \_\_\_\_\_

6. Who is your eye doctor?

Name: \_\_\_\_\_ Optometrist or Ophthalmologist

Phone: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_ Zip: \_\_\_\_\_

7. Has a surgery date been scheduled? Yes or No Date: \_\_\_\_\_

Type of surgery: \_\_\_\_\_

8. Name of hospital: \_\_\_\_\_ Name of Surgeon: \_\_\_\_\_

9. If you live in Fulton or Dekalb County, do you have a Grady Card? Yes Or No

REQUIRED

**Lighthouse Statement:** Please read and sign.

*"I fully understand Lighthouse services are limited to Georgia residents unable to pay for, or receive from other sources, this assistance. In consideration of these services, I release and discharge all persons rendering such services from any claims I may have arising from the services rendered. I am aware that the Lighthouse will not pay for any surgery expense billed to me prior to approval of this application. I also understand that my application will be reviewed by a Lighthouse Provider, and/or the Lighthouse staff. ALL INFORMATION ON AND ATTACHED TO THIS APPLICATION IS TRUE AND CORRECT TO THE BEST OF MY KNOWLEDGE."*

\_\_\_\_\_  
**Signature of Applicant** (or parent if applicant is a child)

\_\_\_\_\_  
**Date**

\_\_\_\_\_  
**Witness** (if applicant signs with an "X")

\_\_\_\_\_  
**Date**

REQUIRED

Complete this portion only if you would like to give us permission to speak with someone else on your behalf regarding your services.

### HIPAA Agreement

I understand that the Federal Privacy Rule ("HIPAA") does not protect the privacy of information if re-disclosed, and therefore request that all information obtained by this person or agency be held strictly confidential and not be further released by the recipient. I further understand that my eligibility for Lighthouse services is not conditioned upon my provision of this authorization. I intend for this document to be a valid authorization conforming to all requirements of the Privacy Rule and understand that my authorization will remain in effect for one year.



\_\_\_\_\_  
**Signature of Applicant** (person applying for services)      Date

I hereby give permission for my medical records to be released to The Lighthouse, Lions Clubs, to any eye care specialist, hospital, medical professional or agency involved with my vision care.

**Name of person/agency permitted to dispense or receive your medical records:**

Name: \_\_\_\_\_ Agency, Physician, Hospital: \_\_\_\_\_

Phone: \_\_\_\_\_

I wish this to remain in effect until: \_\_\_\_\_ (Date)  
(We suggest a minimum of six months)



**REMEMBER to send copies ---not originals!!**

Once completed, send your application and copies of all required documents to us by mail, fax. If you have any questions, please call us at 404-325-3630.

NOTE: When faxing, remember to turn paper to correct side appropriate to fax device. (Each one is different). If you call to confirm receipt, you must have the fax number from which the fax was sent.



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