Adult Vision Surgery Services Application

The Lighthouse is a non-profit 501(c)(3) non-governmental organization. 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 cataracts, glaucoma, and diabetes-related vision loss only, and is available only for adults (ages 19 and older).**

*********************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 (ObamaCare), private insurance or Veterans 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.

If you are unable or unwilling to provide supporting documentation, including but not limited to bank statements, tax returns, and other financial and employment information for yourself ***and*** other members of your household, your application will not be approved. There are ***no*** exceptions. The documentation for surgery is extensive because we work with medical facilities and doctors that require specific information.

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General Information

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!

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 via 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.**

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.)

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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.
4. 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 that patients 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

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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.

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Patient Policies

Appointments

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 of 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.

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Patient Eligibility

The following is an explanation of the documentation required. **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.**

For that reason, we strongly recommend you DO NOT begin the application process until you have ALL required documentation in hand.

Required Documents

Proof of identification, residency and income are required to determine your eligibility. Patients must present:

- **ONE (1)** proof of identification
- **ONE (1)** proof of residency
- **TWO (2)** proofs 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 also provide paycheck stubs for your spouse. If you have a significant other who is part of your household, you must also provide paycheck stubs for him or her.
- All Identification cards must be current, up to date, and legible. We will not accept any expired proof of identification. All identification must have a clear photo of the applicant (you).
- Contact the IRS at 1-800-908-9946 to request a 4506-T Form for non-filing or filing transcript.

1.) IDENTIFICATION: (*Please choose 1*)

- ❑ Unexpired Georgia driver license OR Georgia identification card
- ❑ Consulate ID card or Permanent Resident Alien Card

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

- ❑ Copy of current rental agreement including signature page

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- ❑ 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 three (3) current bank statements
- ❑ 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 (DFCS)
- ❑ 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

4.) ADDITIONAL DOCUMENTATION

- ❑ Your eye doctor's 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

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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.

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.
- 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.

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Vision Surgery Application

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 indicated):____

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 No **13. Are you a Veteran** Yes No

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

Disabled 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 check 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** **NO**

20. Is there anyone other than yourself financially responsible for you? **YES** **NO**

a. If you have answered yes, provide name of person_____________________________ .

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b. Does this person live in your home? YES 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.

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

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!!**

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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 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 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 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 **Date**

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HIPAA Agreement

I understand that the Federal Privacy Rule (HIPAA) protects 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

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

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)

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