Operation Sight Patient Application

VISION FOUNDATION

Patient Information:		
Name:		Date of Birth:
Gender: ☐ Male ☐ Female	Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed	
Current Address:		
Address 2:		
City:	State:	Zip Code:
Home Phone:	Mobile Phone:	Email:

Patient Employment Information:		
☐ Employed ☐ Self Employed ☐ Seasonally Employed ☐ Not Employed		
Employer Name:		Occupation:
Wages/Tips (Before Taxes): ☐ Hourly ☐ Weekly ☐ Bi-weekly ☐ Monthly ☐ Yearly	Average Hours Worked Per Week:	Please check this box if you did not file tax returns: ☐
Other Income ☐ Unemployment: $ _____/ week ☐ Social Security: $ _____/ mo.		☐ Pension/Retirement: $ _____/ mo. ☐ Child Support: $ _____/ mo. ☐ Other: _____ $ _____/ mo.

Household Income & Additional Employment Information (Please include income and employment information for ALL members of the household.)		
Household Member Name (1):		
Employer Name:		Occupation:
Wages/Tips (Before Taxes): ☐ Hourly ☐ Weekly ☐ Bi-Weekly ☐ Monthly ☐ Yearly	Average Hours Worked Per Week:	Please check this box if you did not file tax returns: ☐
Other Income ☐ Unemployment: $ _____/ week ☐ Social Security: $ _____/ mo. ☐ Supplemental Security Income (SSI): $ _____/ mo.		☐ Pension/Retirement: $ _____/ mo. ☐ Child Support: $ _____/ mo. ☐ Other: _____ $ _____/ mo.
Household Member Name (2):		
Employer Name:		Occupation:
Wages/Tips (Before Taxes): ☐ Hourly ☐ Weekly ☐ Bi-Weekly ☐ Monthly ☐ Yearly		Average Hours Worked Per Week:
Other Income ☐ Unemployment: $ _____/ week ☐ Social Security: $ _____/ mo. ☐ Supplemental Security Income (SSI): $ _____/ mo.		☐ Pension/Retirement: $ _____/ mo. ☐ Child Support: $ _____/ mo. ☐ Other: _____ $ _____/ mo.

Household Member Name (3):	
Employer Name:	Occupation:
Wages/Tips (Before Taxes): ☐ Hourly ☐ Weekly ☐ Bi-Weekly ☐ Monthly ☐ Yearly	Average Hours Worked Per Week:
Other Income ☐ Unemployment: $ _____/ week ☐ Social Security: $ _____/ mo. ☐ Supplemental Security Income (SSI): $ _____/ mo.	☐ Pension/Retirement: $ _____/ mo. ☐ Child Support: $ _____/ mo. ☐ Other: _____ $ _____/ mo.
Household Member Name (4):	
Employer Name:	Occupation:
Wages/Tips (Before Taxes): ☐ Hourly ☐ Weekly ☐ Bi-Weekly ☐ Monthly ☐ Yearly	Average Hours Worked Per Week:
Other Income ☐ Unemployment: $ _____/ week ☐ Social Security: $ _____/ mo. ☐ Supplemental Security Income (SSI): $ _____/ mo.	☐ Pension/Retirement: $ _____/ mo. ☐ Child Support: $ _____/ mo. ☐ Other: _____ $ _____/ mo.

Eye Care Services

Have you received a formal cataract diagnosis? ☐ Yes ☐ No	Which Eye: ☐ Right ☐ Left ☐ Both	Last exam date:
Doctor Name/Location of last exam:	Have you been diagnosed with any other eye conditions or diseases? ☐ Yes ☐ No If yes, please explain: _____	
Do you have notes from your doctor visit? ☐ Attached ☐ Unavailable:		

Patient Insurance Status

Do you have insurance? ☐ Yes ☐ No
If no, have you applied for state medical assistance: ☐ Yes ☐ No
Reason for ineligibility (if applicable)?

Additional Patient Information:	
Please tell me how you first heard of Operation Sight.	
What kind of change will this procedure have on your life?	
Operation Sight relies on the generosity of volunteer surgeons and donations. What would you tell someone who was trying to decide if they should volunteer or donate to this program?	
I declare that all parts of this application are true and correct statements, to the best of my knowledge. I understand that the details of this application are solely used to determine my overall financial status and possible eligibility for Operation Sight.	
Signature of Applicant:	Date:

PLEASE FAX YOUR COMLETED APPLICATION FORM AND W-2 TO THE NUMBER LISTED BELOW.

Sioux Falls, SD

(877) 522-3937 | (605) 361-3937
FAX: (605) 371-7035

Fargo, ND

(866) 907-3937 | (701) 566-5390
FAX: (701) 639-7199

Bozeman, MT

1925 N 22nd Ave #201
Bozeman, MT 59718
(866) 620-3937 | (406) 219-0700
FAX: (406) 624-6560

Omaha, NE

(844) 414-3937 | (402) 506-9970
FAX: (402) 401-6420

Alexandria, MN

Clinic: (320) 762-2166
Surgery Center: (320) 335-2167
FAX: (320) 762-8898

Billings, MT

(877) 538-8432 | (406) 294-1994
FAX: (406) 294-1996

South Sioux City, NE

(531) 625-3941
FAX: (531) 625-3940