ASCRS Foundation
IMPROVING THE WORLD'S VISION
AMERICAN SOCIETY OF CATARACT AND REFRACTIVE SURGERY

operation sight

PATIENT INFORMATION:

Name:

Date of Birth:

Gender: ☐Female ☐Male

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:

HOUSEHOLD INCOME AND 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:

Other Income
☐Unemployment: $__________/ week
☐Social Security: $__________/ month
☐Supplemental Security Income (SSI): $________/month

☐Pension/Retirement: $_________/ month
☐Child Support: $_________/ month
☐Other: ___________$ __________/month

Household Member Name (2)

Employer Name:	Occupation:

Wages/Tips (Before taxes):
☐Hourly ☐Weekly ☐Bi-Weekly ☐Monthly

Average Hours Worked Per Week:

Other Income
☐Unemployment: $__________/ week
☐Social Security: $__________/ month
☐Supplemental Security Income (SSI): $________/month

☐Pension/Retirement: $_________/ month
☐Child Support: $_________/ month
☐Other: ___________$ __________/month

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: $__________/ month ☐Supplemental Security Income (SSI): $________/month	☐Pension/Retirement: $_________/ month ☐Child Support: $_________/ month ☐Other: ___________$ __________/month

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: $__________/ month ☐Supplemental Security Income (SSI): $________/month	☐Pension/Retirement: $_________/ month ☐Child Support: $_________/ month ☐Other: ___________$ __________/month

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)**

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ADDITIONAL PATIENT INFORMATION

Please tell me how you first heard of Operation Sight.

What kind of change will this procedure have on your life?

Why do you feel it's important to have programs like Operation Sight?

Would you be willing to share your responses to help raise awareness about Operation Sight?

- ☐ Yes, I would be willing to share my responses and disclose my name.
- ☐ Yes, I would be willing to share my responses, but would prefer my name to not be disclosed.
- ☐ No, I would not like to share my responses.

Please provide any additional information about your interests, daily activities, and challenges due to eye issues. (Optional)

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 SUBMIT YOUR COMPLETED APPLICATION FORM AND PROOF OF INCOME TO emorales@ascrs.org OR BY FAX TO: 703-547-8828 ATTN: Evelyn Morales.