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 ☐ Bi-Weekly
List Amount Selected: $ ____________________

Average Hours Worked Per Week:

Please check this box if you did not file tax returns: ☐

Other Income
☐ Unemployment: $ ____________ / Week
☐ Social Security: $ ____________ / Month
☐ Supplemental Security (SSI): $ ____________ / Month
☐ Pension Retirement: $ ____________ / Month
☐ Child Support: $ ____________ / Month
☐ Other: $ ____________ / Month

HOUSEHOLD INCOME AND ADDITIONAL EMPLOYMENT INFORMATION

Please include income and employment information for ALL members of the household. This includes children.

Household Member Name (1):

Is this member a child? ☐ Yes

Employer Name: | Occupation:

Wages/Tips (Before Taxes):
☐ Hourly ☐ Weekly ☐ Bi-Weekly ☐ Bi-Weekly
List Amount Selected: $ ____________________

Average Hours Worked Per Week:

Please check this box if you did not file tax returns: ☐

Other Income
☐ Unemployment: $ ____________ / Week
☐ Social Security: $ ____________ / Month
☐ Supplemental Security (SSI): $ ____________ / Month
☐ Pension Retirement: $ ____________ / Month
☐ Child Support: $ ____________ / Month
☐ Other: $ ____________ / Month

Household Member Name (2):	Is this member a child? ☐ Yes
Employer Name:	Occupation:

Wages/Tips (Before Taxes): ☐ Hourly ☐ Weekly ☐ Bi-Weekly ☐ Bi-Weekly **List Amount Selected: $** ____________	Average Hours Worked Per Week:	Please check this box if you did not file tax returns: ☐

Other Income

☐ Unemployment:	$ ________	/ Week	☐ Pension Retirement:	$ ________	/ Month
☐ Social Security:	$ ________	/ Month	☐ Child Support:	$ ________	/ Month
☐ Supplemental Security (SSI):	$ ________	/ Month	☐ Other:	$ ________	/ Month

Household Member Name (3):	Is this member a child? ☐ Yes
Employer Name:	Occupation:

Wages/Tips (Before Taxes): ☐ Hourly ☐ Weekly ☐ Bi-Weekly ☐ Bi-Weekly **List Amount Selected: $** ____________	Average Hours Worked Per Week:	Please check this box if you did not file tax returns: ☐

Other Income

☐ Unemployment:	$ ________	/ Week	☐ Pension Retirement:	$ ________	/ Month
☐ Social Security:	$ ________	/ Month	☐ Child Support:	$ ________	/ Month
☐ Supplemental Security (SSI):	$ ________	/ Month	☐ Other:	$ ________	/ Month

Household Member Name (4):	Is this member a child? ☐ Yes
Employer Name:	Occupation:

Wages/Tips (Before Taxes): ☐ Hourly ☐ Weekly ☐ Bi-Weekly ☐ Bi-Weekly **List Amount Selected: $** ____________	Average Hours Worked Per Week:	Please check this box if you did not file tax returns: ☐

Other Income

☐ Unemployment:	$ ________	/ Week	☐ Pension Retirement:	$ ________	/ Month
☐ Social Security:	$ ________	/ Month	☐ Child Support:	$ ________	/ Month
☐ Supplemental Security (SSI):	$ ________	/ Month	☐ Other:	$ ________	/ Month

EYE CARE SERVICES

Have you received a formal cataract diagnosis? ☐ Yes ☐ No	Which Eye? ☐ Right ☐ Left ☐ Both	Last Exam Data:
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 ☐ Please contact Dr. ______________________

What is the maximum distance you can travel for your surgery and appointments (in miles)? ____________

If we do not have active volunteer surgeons in your immediate area, your travel capacity may affect how quickly we are able to match you.

PATIENT INSURANCE STATUS

Do you have insurance? ☐ Yes ☐ No	If no, have you applied for state or county medical assistance? ☐ Yes ☐ No	Please list reason for ineligibility for state or county assistance (if applicable):

ADDITIONAL PATIENT INFORMATION

Please tell me how you first heard of Operation Gratitude.

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

Operation Gratitude relies on the generosity of volunteer surgeons and donations. What could you tell someone who was trying to decide if they should volunteer or donate to this program?

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

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

- ☐ 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 REGARDING INTERESTS, DAILY ACTIVITIES, AND HOBBIES.

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 soley used to determine my overall financial status and possible eligibility for Operation Gratitude.

Signature of Applicant: ______________________________ **Date:** ____________________

PLEASE SUBMIT YOUR COMPLETED APPLICATION FORM AND THE ADDITIONAL REQUESTED DOCUMENTATION TO:

OmniEyeFoundation@OOMC.com or by fax to: 732-510-2542