GEORGE FOUNDATION
FOR SIGHT RESTORATION

Please print legibly, in ink

George Foundation for Sight Restoration
PO Box 795391
5995 Summerside Dr. Dallas, TX 75248
(904) 403-4091 FAX: (972) 570-1103
helpgivesight@gmail.com

Patient Name: (Last, First, Middle Initial)

_____

Date: _____

Are you a current GFSR Foundation Patient? _____

Who referred you to GFSR? _____

Who is your physician? _____

For what type of medical eye problem(s) are you seeking help?

_____

Birth Date _____

Social Security Number _____

Home Phone _____

Work Phone _____

Cell Phone _____

Address

_____

Total number of persons in household: _____

Optional

☐ Anglo ☐ African-American ☐ Latin ☐ Asian ☐ Other

☐ Male ☐ Female

Number of wage earners in household _____

County of Residence _____

City _____

State _____

Zip Code _____

Yearly Household Income _____

PLEASE ANSWER YES OR NO

1. Do you have health insurance? ____

2. Do you have Medicare? ____ Do you have Medicaid? ____

If NO, have you applied for it? ____

3. Do you have county medical assistance? ____ If No, have you applied for it? ____

4. Are you currently employed? ____ If NO, is your unemployment due to vision issues ____

5. Do you live in Texas permanently? ____ **6.** Do you file income taxes? ____

7. Have you exhaused other available options, such as 401k, retirement fund, assets, available funding from family, or friends? ____

Please submit the following documents along with this completed application:
Do not send originals. The GFSR office will not photocopy and return any documents.

- [ ] **SUGGESTED**: Denial letter from residing county indigent health program.

- [ ] **REQUIRED** - Copy of household tax return for the year prior to application.

- [ ] **REQUIRED** - Copy of the last two paystubs that includes year-to-date figures for all working individuals in the household, or a handwritten letter from each employer. If unemployed, a copy of any financial award letters from disability, social security, or unemployment offices. If unemployed and living with family members, send proof of household income for the family and letter from family confirming they are financially supporting the applicant.

- [ ] **REQUIRED** - If applicant has private, medical insurance, a copy of the insurance care, and insurance plan that states the deductible.

- [ ] IF applicant is over 65 years of age, a denial letter from Medicaid/Medicare is required.

- [ ] IF applicant is receiving disability income, a denial letter from Medicare / Medicaid is required.

Your Employer _____

Spouse's Employer (If applicable) _____

Position _____

Position _____

Yearly gross income _____

Yearly gross income _____

Rent/Mortgage _____ **Electricity** _____ **Telephone** _____

Food _____ **Car** _____ **Child Support (if applicable)** _____

I understand that if I qualify as a GFSR patient, my status as a GFSR patient may be IMMEDIATEY revoked if I fail to disclose all financial assets or if the Foundation becomes aware of undisclosed and available financial support while benefitting from GFSR's donated services. I also am confirming that the information listed above is accurate to the best of my knowledge:

Applicant's Signature and Date