Please type, or print legibly, in ink

George Foundation for Sight Restoration
PO Box 795391
(972) 209-0124   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 exhausted 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 pay stubs 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 IMMEDIATELY revoked if I fail to disclose all financial assets or if the Foundation becomes aware of undisclosed and available financial support while benefiting 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