Application and Documents Needed for Cataract Surgery

3100 N MacArthur Blvd. Irving, Texas 75062 | (979) 985-3022

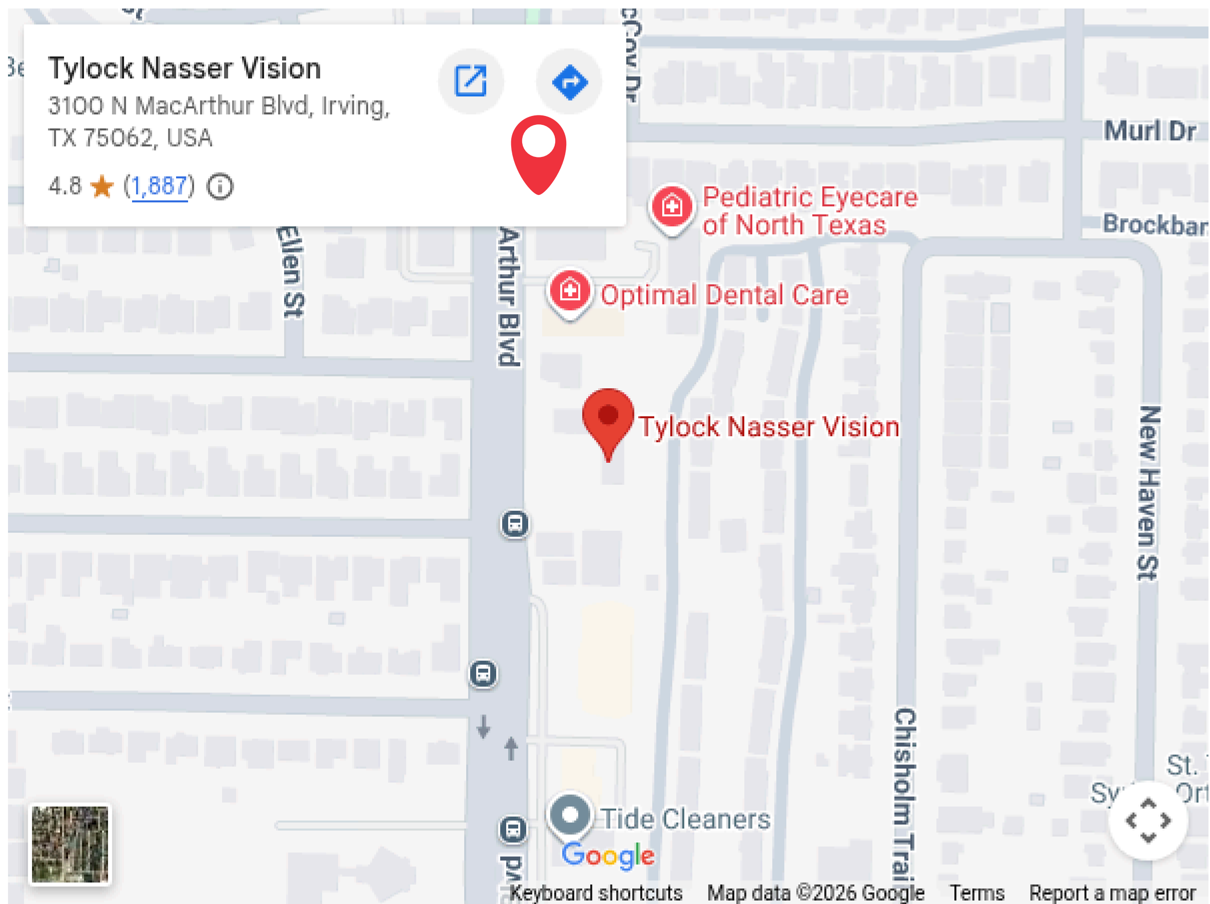
1. Cornerstone application
2. Alcon application
3. Copy of the patient identification
4. Financial documents from patient or spouse
    1. Income - four recent check stubs or income tax return
    2. Copy of Social Security income and Social Security Disability, WIC, TANK, Food Stamps, or copy of any government help
    3. Medicare A, B, C, D documentation
    4. Insurance documentation
5. Homeless: A letter from an organization to verify homeless status
6. If patient is not working, financial documentation of family income is needed
7. List of current medications

You can mail or drop of these documents at 3100 N MacArthur Blvd, Irving, Texas, 75062. If you have any questions, feel free to call our office at (979) 985-3022 or send a fax to (972) 570-1103.

If any information given is incorrect or missing, your request will be delayed or disqualified.

Patient signature: ______________________________ **Date:** ______________________

3100 N MacArthur Blvd. Irving, Texas 75062 | (979) 985-3022



From Dallas (East)

- Take TX-183 W toward Irving
- Exit MacArthur Blvd
- Turn right (north) on MacArthur Blvd
- Continue about 1 mile
- Tylock Nasser Vision will be on the right

From Fort Worth (West)

- Take TX-183 E toward Irving
- Exit MacArthur Blvd
- Turn left (north) on MacArthur Blvd
- Drive about 1 mile
- The office will be on the right

Crown Vision Foundation Qualifications

3100 N MacArthur Blvd. Irving, Texas 75062 | (979) 985-3022

Who can qualify?

Must be a Tarrant County Resident, No Insurance and fall below 200% of the Federal Poverty Level.

What will I need to apply?

Proof of ID, Proof of Tarrant County Residence and Proof of Income.

Proof of ID

Must provide ONE of the following:

- ☐ Valid Drivers' License or State Issued ID Card
- ☐ Permanent Resident, Consular or Passport Card
- ☐ TDJC Card
- ☐ TCHC or Homeless Shelter ID Card
- ☐ Bus ID Card

Proof of Tarrant County Residence

Must provide ONE of the following:

- ☐ Utility bill with patient's name and address
- ☐ Agency letter – Re-entry, New Lives, Family Services
- ☐ Rental/lease agreement with patient's name
- ☐ Mortgage Statement
- ☐ Insurance Document
- ☐ Letter from Government Agency

Proof of All Household Income

Must provide copies for all that apply:

- ☐ Check Stubs for the last 30 days for everyone living in the household over 18 years of age
- ☐ Current Award Letter for SSI, RSDI, VA, Social Security or TANF
- ☐ Employer Wage Verification - If paid in cash
- ☐ Unemployment Award Letter
- ☐ Workman's Compensation
- ☐ Proof of child support
- ☐ Current year Income tax information
- ☐ Verification of Assistance Form
- ☐ Government assistance (Food Stamps, also known as SNAP, Medicaid, or TANF)
- ☐ Government funded housing (Section 8)

How do I submit my application?

Completed applications can dropped off at our office, faxed to (972) 570-1103, or emailed to CrownVisionFoundation@tylock.com

How long will the process take?

It typically takes 3-4 weeks to review your application, and schedule an exam appointment if you qualify.

Crown Vision Foundation
Assistance Network Intake Form

3100 N MacArthur Blvd. Irving, Texas 75062 | (979) 985-3022

Client Information

Name (First, Middle, Last):		Date:
Current address:		
City:	State:	ZIP Code:
Home Phone:	Work Phone:	Cell Phone:
Email:	Date of Birth:	Age:

Emergency Contact:	Emergency Contact Phone #:

Crown Vision Foundation does not discriminate on the basis of race, sex, gender, age, linguistic and language ability, marital status, disability and any other characteristics protected by law.

Demographic Information

Race/Ethnicity (Please check all that apply):		**Citizenship:**
☐ American Indian/Alaskan Native	☐ Native Hawaiian/Pacific Islander	☐ US Citizen
☐ Black/African American	☐ White	☐ Eligible Non-Citizen
☐ Hispanic	☐ Other ________________	☐ Non-Eligible Non-Citizen

Gender:	**Veteran:**	**Disabled:**	**Bilingual:**
☐ Male	☐ Yes	☐ Yes	☐ Yes
☐ Female	☐ No	☐ No	☐ No

Marital Status:		**Education Level:**	
☐ Single/Never Married	☐ Separated	☐ Less than High School	☐ High School/ GED
☐ Married	☐ Common Law	☐ Some college/Associate	☐ Bachelor's Degree
☐ Divorced	☐ Widow	☐ Advanced Degree	☐ Other ______________

Household Information

Employment Status:		**Yearly Income:**		**Source(s) of Income:**	
☐ Unemployment	☐ Self Employed	☐ < $10K	☐ $21K-$25K	☐ Employment	☐ SSI/SSDI
☐ Part Time	☐ Retired	☐ $11K-$15K	☐ >$26K+	☐ Child Support	☐ TANF
☐ Full Time	☐ Other__________	☐ $16K-$20K	☐ Other ______	☐ Pension/Veteran	☐ Other________

Housing Status:		**Transportation:**		**Number of Persons in Household:**
☐ Own Home	☐ Transition Housing	☐ Bus	☐ Walking	☐ Children (under 17): ______
☐ Rent	☐ Homeless	☐ Personal Vehicle		☐ Adults: _______
☐ Staying With Someone	☐ Other ________	☐ Received Ride		

Please list ALL individuals currently living in your household

Name	Date of Birth	Age	Gender	Relationship

PLEASE ALSO COMPLETE THE BACK PAGE

Programs

Please rank you current level of need (1 being the least and 5 being the most):

1	2	3	4	5

What mainstream benefits have you applied for or participated in? Check all that apply

☐ SSI/ SSDI	☐ JPS Connection	☐ Education Assistance	☐ TANF	☐ Medicaid
☐ Food Stamps/WIC	☐ Section 8 Housing	☐ Workers Comp.	☐ Texas Workforce	☐ ACA Marketplace

Income received from any source in past 30 days:

Source of Income:	Amount Monthly:
Employment:	
Unemployment	
Social Security	
SSI/ SSDI	
Veterans benefits	
Worker's comp	
Alimony / Child Support	
TANF	
Other Sources:	

Non-cash benefits received in past 30 days:

Type of Benefits:	Amount Monthly:
Food Stamps	
Medicaid	
Medicare	
CHIP	
VA Medical services	
Section 8, Public Housing	
Other:	

Critical Documents Needed:

☐ Valid Driver's License	☐ Valid ID
☐ Social security Card	☐ Birth Certificate
☐ Permanent Resident	☐ TDCJ/TCHC

Monthly Expenses:

Type:	Amount Monthly:
Rent / Mortgage	
Auto / Payment	
Gas	
Insurance	
Utilities: Electric	
Gas	
Water	
Phone	
Food	
Childcare	
Alimony / Child Support	
Medical Insurance	
Prescriptions	
Cable / Internet	
Other Expenses	

Are you seeking any of the following services?

Addiction Services:	☐ Yes
	☐ No
Adult Education Services:	☐ GED Classes
☐ Computer Classes	☐ ESL Classes
Spiritual Resources:	☐ Bible
☐ Church information	☐ Prayer
Lifestyle Management	☐ Financial Budgeting
☐ Immigration Svcs	☐ Coaching
☐ Emotional Support	☐ Legal assistance
☐ Health	☐ Dental
☐ Eye	☐ Mental health
Reentry services	☐ Job
☐ Housing	☐ Transportation
☐ Interview skills	☐ Resume

Re-entry Information

☐ Felony Conviction	☐ Open/ Pending Case	☐ Unpaid tickets/ Warrants
☐ Misdemeanor Conviction	☐ Probation/ Parole	☐ Current civil cases

CLIENT/PATIENT SIGNATURE: **REFERRING INDIVIDUAL/ORGANIZATION:**

***Please submit page one first for pre-approval with copies of proof of income.**

Indigent Patient Surgery Program Application

Providing the integral link between the healthcare service provider and our local communities to help preserve and restore sight to the underserved.

Alcon Cares, Inc.

Alcon Cares, Inc. (ACI) offers a voluntary public service program that provides products to qualified individuals at no charge. Each request is subject to approval, and fulfillment is based upon current available resources. ACI reserves the right to modify or discontinue this program at any time. Products eligible for reimbursement are not to be sold, traded or used for any other purpose.

ACI Contact Information

Telephone: 800.222.8103
Fax to: 866.594.1579
E-mail to: Indigent.Surgery@Alcon.com

Surgery Contact Information

Surgery Facility and Acct. Number: ______________________
Surgery Facility Contact Name: ______________________
Surgery Facility Contact Email: ______________________

Patient Information Section

Patient Name: ______________________ Date of Birth: __________

Street Address: ______________________

____
City State ZIP Code

Marital Status: ❑ Single ❑ Married ❑ Widowed U.S. Citizen: ❑ Yes ❑ No

Number of Persons Financially Supporting Household: ______ Number of Persons Dependent on Household Income: ______

Does the patient have Medicare? ❑ Yes ❑ No Medicare Plan Type: ______________________

Total Household Annual Income (Gross): ______________________

Please provide supporting income documents, such as most recent federal tax return or other proof of household income.

Patient Authorization: I certify that I have provided my prescribing physician with all of the necessary consents authorizing him/her to release my health information to ACI. Unless revoked, this authorization will remain in effect for the duration of my participation in the program.

Declaration Regarding Privacy: I understand and agree that ACI and parties working on its behalf may use and disclose my information to determine my eligibility for this program; administer and improve ACI programs, products, and services; communicate with me about my experience with this program; send me educational materials and other helpful information and updates relating to ACI programs; and/or as ACI believes to be necessary or appropriate under applicable law, to submit required reports and government filings, to comply with legal processes, to respond to requests from government authorities, and to protect our rights, privacy, safety, or property. I further understand that, once my information is disclosed, ACI cannot control how the recipients will further use or disclose my information.

Declaration Regarding Incurred Drug Expenses: I understand and agree that the value of any free medications provided to me pursuant to this program does not count as true out-of-pocket spending ("TrOOP") under Part D of the Medicare program or any other prescription drug plan. I further agree that I will seek no reimbursement for any medications obtained under this program.

Applicant Declaration Regarding Accuracy and Completeness of Information: I certify that the information on this form is correct and complete. If needed, ACI may request and obtain additional information about me or my family's income to enroll me in the Program. Please indicate your agreement with these terms by initialing here: ________

Patient Acknowledgment: I acknowledge that my participation in the program is subject to ACI's approval and ACI expressly reserves the right to refuse my participation. Please indicate your agreement with these terms by signing below.

Patient Signature: ______________________ **Date:** __________

For Alcon Cares, Inc. Internal Office Use Only

❑ Approved

If your patient's application has been approved, please return this form with a completed page two within 90 days after the surgery has been performed to receive credit.

❑ Declined

Your patient's application has not been approved for to the following reason(s):

____

____

***Please submit page one first for pre-approval with copies of proof of income.**

Indigent Patient Surgery Program Application

Healthcare Provider Section

Surgery Facility Name: ______________________________

Surgery Facility Contact Email: ______________ Surgery Facility Contact Name: ______________

Surgery Facility Street Address: ______________________________

____

City State ZIP Code Phone

Healthcare Provider State License #: ______________ State: ______________

Healthcare Provider Name: ______________________________

First Last

Healthcare Provider Business Hours: ______________ Office Contact Name: ______________

Tax ID #: ______________ Medicare Provider #: ______________

The products listed will be credited the healthcare provider's account. **ACI recognizes the fact that the prescribing healthcare provider has the sole responsibility in determining the product best suited for his/her patient.**

Patient Name: ______________ DOB: ______________

Surgery Type (cataract, glaucoma, vitreoretinal, etc.): ______________

Alcon Products Used (except IOLs)

Product Number	Lot Number	Description	Quantity

Note: Only list surgical products sold or distributed by Alcon. This program does not apply to products sold or distributed by Novartis.

Alcon IOLs Used

Lens Style	Serial Number	Diopter	Left or Right Eye

If you require additional lines, please copy this form and complete the product section with the additional products and attach it to the application.

I certify that the information proved in this form is correct and I understand that the medication provided to the qualifying patient will be credited to my account. I will not submit any claim for reimbursement to any public or private third party payer (e.g., Medicaid, Medicare, private insurance, etc.) for the products used on a qualifying patient under this program. I further certify that I have obtained all necessary consents authorizing me to release protected health information to ACI. Neither I nor the facility will charge any patient receiving free product under this program or any third party for services performed by me or the facility. **I understand that participation in this program is not intended as an incentive or reward for recommending or using any Alcon product.** I further understand that products provided under this program may not be sold or traded and may not be returned for credit. My signature below confirms that I agree to these terms as further articulated in the Guidelines attached and that there is a valid medical need for this patient's prescription.

Healthcare Provider's Signature: ______________ **Date:** ______________

If applicable, collaborating Physician's Name: ______________

State License #: ______________

Please indicate account number to receive credit: ______________

Indigent Patient Surgery Program Application

Guidelines

The program is open to any private patient of a U.S.-licensed healthcare provider who meets the financial guidelines set forth herein and who cannot afford the required products. Eligibility is based on several factors, including income limits that are tied to U.S. Government Census Bureau figures. Because the guideline documents are large and complex, we do not provide them here but can explain them to you over the phone. Relevant U.S. Government Census Bureau information may be found in public sources such as the internet or the library. However, patients will likely qualify for the income test at 250% (two-and-a-half times) the current year's poverty level under the number of persons living in a household. Current Health and Human Services guidelines can be found at http://aspe.hhs.gov/poverty/.

We require the healthcare provider to complete his/her section of the application on behalf of his/her patient. The healthcare provider also agrees not to proactively market the program beyond communicating its existence and availability to his/her patients. There are no product purchase requirements by the patient for participation in the program. The healthcare provider also agrees to comply with an audit, if necessary, of his/her facilities and program operation to ensure compliance with these guidelines.
There are no charges to the patient or any third party for any services or products provided under this program.

There are no charges to patients or healthcare providers for access to this program.
The program's guidelines are based upon the manufacturer's ability to donate product. We would like to accommodate all requests, but we cannot. Our criteria, guidelines, and limits help us to meet the needs of those patients most in need.

For inquiries about the program or to get the latest application, call ACI at 1-800-222-8103 or email at indigent.surgery@alcon.com. Patients should contact their healthcare provider, who will be able to obtain our application, which will screen for eligibility based upon income, household information, medical information, and other factors.

Application Process and Requirements:

- The healthcare provider completes page one of the application and submits it to ACI for review and approval prior to surgery.
- ACI will review page one of the application and notify the healthcare provider of its status.
- If the patient's application is approved, the healthcare provider will complete page two of the application after the surgery has been performed and return it to ACI by email, fax or mail (see below for details).
- Incomplete or illegible applications will not be honored.

Completed applications may be submitted using one of the following methods:

E-mail: **indigent.surgery@alcon.com**
Fax: **866-594-1579**
Mail: **Alcon Corporate Giving • TC39 • 6201 South Freeway • Fort Worth, TX 76134-0450**.

If no follow-up information is required and the application has been approved, we will begin the process to credit the healthcare provider or facility account.

If a patient is denied, a letter will be sent to the healthcare provider or facility stating the reasons for denial and the action necessary to resubmit the application. In cases that required criteria are not met, the application will not be eligible for resubmission.

Power of Attorney is permissible, but appropriate documentation must be provided to ACI when the patient is physically unable to sign the application. Witness of signature by healthcare provider office personnel is permissible when the patient has trouble signing his/her name and the healthcare provider office personnel signs that he/she witnessed the patient signing his/her name.

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Zero Income Statement

Date: ____________________

Patient Name: ___________________________________Date of Birth __________________

1. I am signing this letter to declare that I currently do not have any income from any source. My financial support comes from (please describe):

   Did you file a federal income tax return in the past two years? (circle one) No Yes
   If yes, submit a copy of your most recent federal tax return.

2. I agree to notify the above provider about changes in my income within 30 days of the change.

3. _________________is a resident of the _______________________shelter and has no income.

4. I understand that by completing, signing and dating this form, I declare that I have no household income and that the information I am providing is correct. I understand that providing false information may result in denial of services.

Patient Signature: ____

Referring Provider: ____

1. I attest that the above patient has no source of income and qualifies for services outlined by the Alcon Indigent Patient Surgery application Guidelines.

Provider Signature: ____

6201 South Freeway
Fort Worth, Texas 76134-2099
Phone: +1(800)-222-8103 Fax: +1(866)-594-1579
Indigent.surgery@alcon.com

Health Services Verification of Assistance and/or Residency

3100 N MacArthur Blvd. Irving, Texas 75062 | (979) 985-3022

Please have this form completed and signed by the person that is providing the support.

I, ______________________________ verify that ______________________________ lives at
Name of person providing assistance — Applicant's name

____
Applicant's address — City — State — Zip

Financial Assistance:

Do you provide financial assistance to the applicant? ☐ Yes ☐ No

Did you claim the applicant on your most recent Federal Income Tax return? ☐ Yes ☐ No

What type of assistance do you provide for the applicant?

☐ Rent ☐ Mortgage ☐ Utilities ☐ Food ☐ Personal Items ☐ Transportation

☐ Cash/Check ☐ Other: ____________________

Please indicate how much and how often is the financial assistance given?

$ ____________________ ☐ Weekly ☐ Monthly ☐ Other: ____________________

Residency Assistance:

Does the applicant reside at you're address? ☐ Yes ☐ No

How long has the applicant lived at this address? ______________________________

Does the applicant contribute monetarily to help towards the rent and/or utilities? ☐ Yes ☐ No

If yes, how much and how often?

$ ____________________ ☐ Weekly ☐ Monthly ☐ Other: ____________________

The information provided will solely be used to determine if the applicant qualifies for our services. I certify that the above information is true and correct. I further understand that providing false information may result in denial or termination of services for the applicant.

Signature of Person Providing Assistance: ______________________________ Date: ________________

Relationship to Patient: ____