Date of Surgery: _____ Date of Application: _____

Application for Medical or Surgical Eye Care Assistance

Patient Name: _____ Birthdate: _____

Address: _____

Phone Number: _____ Contact Person: _____

US Citizen (check one): _____ Yes _____ No, if **no**, how long have you been in the US? _____

Do you speak English? _____ Yes _____ No, if **no**, what is the primary language spoken? _____

Do you have someone that can interpret? ____ Yes ____ No, If **yes**, interpreter's name _____

Marital Status (check one): _____ Single _____ Married _____ Widowed _____ Divorced

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How many people are in your household? _____ Adults _____ Children

How many people in your household have income of any kind? _____ Total monthly income _____

Have you applied for Medicaid or Colorado Shared Insurance? _____ Yes _____ No _____ Application Pending

Do you have health insurance? _____ Yes _____ No, if **yes,** name of insurance: _____

Did you or anyone in your household file a tax return last year? _____ Yes _____ No

***Please attach copies of the last 3 pay stubs for all employed household members. If on social security, please attach your SSD quarterly or annual statement. If anyone in the household filed a tax return last year please attach a copy.**

Type of Medical or Surgical Services Requested: _____**Surgeon _____**

A financial contribution will need to be made toward your eye care. Please indicate below the amount you or your family will be able to contribute towards **each surgery.** **This is a one-time payment due on the date of surgery.**

Amount to Pinnacle Surgery Center: _____ Initials: _____

Amount to provider for office visit services only (exam/glasses/contact lenses): _____ Initials: _____

My signature below certifies the following:

1. The information on this form is correct and complete.

2. I shall not seek any reimbursement from any insurance provider or payer (public or private) for any services rendered.

Patient's Signature: _____ Date: _____

Business office: this patient was approved on _____: initials: _____