Please turn in this application with all the required documentation.

Turn in applications at the front desk any time during normal business hours.

Applications submitted without required documentation will be DENIED.

Required Documentation:

1. **Completed "Eye Care Intake" Application**
2. **Proof of Residency**
    - Proof of residency will only be accepted as a current rental agreement or a utility bill (must have applicant's name and address on bill).
3. **Proof of Income**
    - Proof of income includes Employment, Social Security Disability Benefits, or proof of full time student enrollment.
4. **Photo ID and Social Security Card**

Eye Care Intake

 # in Family________ **Date____/____/____**

Client Name:____

Address____

Mailing Address (If different from above)_____________________________________

Phone #__________________ **Zip Code________________**

Gender: Male Female **Birth Date_____/_____/_____**

Social Security # ______-_____-______ **License or ID#____________**

Ethnicity (Circle all that apply)

African American
Caucasian
Asian
Hispanic
Native American
Other______________

Please List All Others in the Household

Name	Relationship	Birth Date
1.		
2.		
3.		
4.		
5.		

Release of Information/Confidentiality

I,____________________, herby authorize Catholic Charities of the Texas Panhandle to disclose and/or obtain information concerning myself to and/or from Department of Human Services, other public assistance agencies, employers, and physicians. I understand that such information with be used to determine eligibility and assistance for me and/or my family through Catholic Charities. I further understand that any information obtained or given about myself is protected under strict confidentiality laws.

____________________________________ ______________
Client Signature Date

____________________________________ ______________
CCTXP Staff/Volunteer Date

Client Name__________________________
Date_________________

EYE CARE QUESTIONNAIRE

Are you 19 years of age or older? YES NO

Are you working or on, SSI, SSDI, SI, or a student? YES NO

Please Circle all that apply:
- Employed
- SSI
- SSDI
- SI
- Full Time Student

Please Specify Monthly Income ___________

Do you have proof of income? YES NO
Do you have a picture ID? YES NO
Do you have a social security card? YES NO
If a student, do you have proof of enrollment? YES NO
NOTE: You must have all the above documentation for certification

Do you need glasses to obtain employment? YES NO
IF YES please list name of employer and Phone Number
Name:________________________ Phone:_________________

NOTE: Please attach a letter from the employer willing to hire you pending an eye exam. This must be a pre-existing offer to qualify.

Do you have insurance? YES NO

Have you received services from **our** eye care program in the past? YES NO
Please indicate about when:_________________________

Date of Last Eye Exam:___________ Physician:____________

NOTE: If you have received services within the past three years, your application will be denied. This service is for people who NEED eye glasses, not who want them.

Please Initial All the Following and Sign at the Bottom

______ The prescription I receive from the doctor is for GLASSES only. Catholic Charities does not send clients for contact lenses or sunglasses exams.

______ The Doctor who performs this exam for me is NOT my primary physician and will not be responsible for filling out medical forms, disability verification, etc.

______ The combined income for all persons in my household is below $2000.00 per month.

______ I will not be seen by a caseworker at Catholic Charities or by the eye doctor if I show up under the influence of alcohol or drugs.

______ All doctors have the right to refuse your referral based on their judgment.

______ The doctor does not provide clients with frames or lenses. Once I receive my prescription, I will return to Catholic Charities and see a caseworker to choose a pair of frames and a referral for lenses.

Qualifying clients must not miss an appointment without calling the doctor ***and*** *Catholic Charities at least 24 hours in advance. Clients will not be allowed to benefit from our program if they fail to do so. Doctors donate their time and service and we cannot abuse their time or service.*
Do you understand the above statement? YES NO

I certify that all the information provided within this packet is true to the best of my knowledge. If anything is found to be false, my appointment may be cancelled and I will not be eligible for future services.

______________________ ___________________________

Printed Name Client Signature

WHEN TURNING IN YOUR APPLICATION, MAKE SURE TO HAVE IT REVIEWED BY A CASEWORKER. IF YOU ARE CONSIDERED ELIGIBLE, AN APPOINTMENT WILL BE MADE FOR YOU. PLEASE DO NOT CONTACT THE CCTXP RECEPTIONIST ABOUT THE STATUS OF YOUR CASE.