New England Eye/Renaissance School Vision Center: AFFORDABLE EYE CARE PROGRAM

Please fill out this form if your child does not have active health insurance or if you are concerned that your insurance does not cover vision care.

It is the mission of the New England Eye Institute to provide comprehensive eye care of exceptional quality to all persons from Boston and the surrounding communities. In order to comply with regulatory requirements as well as satisfy the requirements of our insurance carriers, we request that patients seeking adjusted or reduced fees for services complete an application including documentation when indicated.

The information provided her is confidential and will only be used for determination of need by the New England Eye Institute. If approved the determination will be valid for up to one year or until a change in financial status occurs. Any changes to financial status must be reported immediately. This Financial Assistance Program is a payer of last resort. Other insurances must be billed/verified prior to using this program

Some helpful suggestions:

- You **must** provide documentation of income for household. Examples included 4 recent pay stubs or copies of current year Income Tax or W-2 Forms.
- Please complete every line of the application. Please write N/A if a question does not apply to you.
- Please print clearly. Attached additional sheets of paper if you need more space.
- Review your eligibility for Public Assistance with your local Welfare Office, if necessary. You may be requested to do so prior to obtaining private assistance from this institution.
- Contact our Director of Operations/designee if you have any questions or require assistance with this application.
- Written authorization from referral agency may be required if you cannot provide documentation to support the information requested on this form.

Patient Name: ______________________________DOB:___________ Social Security: _______ - ______ - _______

Address: ____Phone Number: ________________

Guarantor: (if needed) ____

Address: ____ Phone Number: ________________

Employer: ________________________________Employer Phone Number: ___________________

Household Income: _____________________ weekly / monthly / yearly Family Size:___ Married___ Single___

ATTACH VERIFYING SOURCE OF INCOME – ie: 4 Pay Stubs; Tax Return; W-2 Form; etc. for household
-OR-

□ Check here if you would like the Vision Center to use your child's free/reduced meals status as verification of income.

I certify that the information provided is correct and authorize verification of this information. If at any time my financial status changes, I will notify you immediately. If at any point it is determined that the information provided to New England Eye Institute is inaccurate or misleading, we have the right to implement procedures to collect monies due.

Patient Signature: ____ **Date:** _______________

Guarantor Signature: ____ **Date:** _______________

FOR OFFICE USE ONLY

Date _________________	**Expiration Date**_______________
Approved _________________	**Denied** _________________
UCMP Percent _________%	**Verification Complete:**_____________
Patient Responsibility _________%	**Initials** ____________

10/12/2010