Application for Vision Services

This application is ONLY for eye exams and eyeglasses. Eye surgery and hearing aids have separate applications. Do not complete this application unless you are seeking an eye exam or eyeglasses.

The Lighthouse is a non-profit, non-governmental organization that provides health care with dignity and respect to uninsured, low-income people in Georgia. **We are not a free clinic.** Service eligibility is based on income.

Lighthouse vision services include: free eye exams provided by a volunteer eye care professional and low cost eyeglasses

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Please note: Due to COVID-19, we are NOT accepting walk-in applications.
Please mail or fax as directed on the application pages.
PLEASE READ ALL OF THE INFORMATION PROVIDED. IT WILL ANSWER MANY OF YOUR QUESTIONS AND ELIMINATE THE NEED TO CALL.

THE APPLICATION IS AT THE BACK OF THIS PACKET (PAGES 10 -11).

PLEASE DETACH THESE PAGES (10 – 11) AND SUBMIT WITH COMPLETE DOCUMENTATION.
If you are unable or unwilling to provide the documentation, your application will not be approved.

General Information

Where to Find Us:
The Lighthouse office, which also houses our Chamblee Vision Clinic, is at **5582 Peachtree Road Chamblee, GA 30341.**

Red/Gold Line (1 mi. north of Chamblee station)
Or via #132 Bus Line from Chamblee station

Contact Information:
Phone: 404-325-3630 (listen to menu for choice of service)
FAX: (***Vision Only***) 404-636-5549

Hours of operation for The Lighthouse main office: Mon. – Fri. | 9:00 AM – 5:00 PM

Hours of Operation for the Chamblee Clinic: Tues., Wed., and Thurs. | 10:00 AM – 3:30 PM
(Clinic closes for lunch from 1:00PM– 2:00 PM)

Note: This is subject to change at any time due to COVID-19 developments.

Appointments for Chamblee Clinic
Upon approval of application, patients will be called to schedule an appointment and will be based on availability of an eye doctor.

Submit Application & Required Documents → Receive Approval Letter → Schedule Appointment

Due to new safety protocols, we no longer accept walk-ins patients at Chamblee Clinic
You must make an appointment via the clinic manager, if you have BOTH of the following:

1) An approval letter from The Lighthouse
2) A current prescription for eyeglasses

Mobile Clinics

We have partnerships across the state of Georgia that allow us to provide vision care through our mobile clinics. These vary on a monthly basis. If your application is approved, you will be scheduled for one of our mobile clinics that is closest to your location.

Payment and Fees

All eye exams are free for eligible patients. Eyeglasses start at $15.00 with possible mandatory fees added based on the severity of your prescription. Any cosmetic upgrades that you choose will have an additional fee. We **do not** accept insurance. We **do not** accept checks. We accept cash, money orders and credit or debit cards. (Visa and MasterCard only).

Application Requirements

Due to COVID-19, we are briefly suspending our requirements for proof of income. You are not required to submit financial documentation from July 1, 2020 through December 31, 2020. This is a short-term measure, and will be re-evaluated at the end of this period.

In addition to a **completed** application, you must submit supporting documentation to prove your income, identification, and residency. Types of acceptable documentation are listed below.

1.) Basic Eligibility Qualifications

To qualify for Lighthouse program services, you must:

- Have been a Georgia resident for at least 12 months
- Meet our income requirements
- Submit copies of ALL required documents. If any of the documents are not included with your application, your request will not move forward

2.) Acceptable Documents

Proof of income, identification, and residency are required to determine your eligibility. Patients must provide documents **as indicated in boxes belo**

Proof of Gross Income

(Choose at least one (1)
(Not required 7/1/20 – 12/31/20)

- 2 current consecutive paycheck stubs for bi-weekly pay; or 4 current consecutive paycheck stubs for weekly pay
- Last **3** months of bank statements
- Official tax transcript
- Social Security/Disability award letter
- 4506-T form (non-filing)
- College/University scholarship, grant, fellowship, or assistantship
- Regular payments from alimony, child support, unemployment, union funds, retirement, or other government program

Proof of Identification

(Choose 1)

- Valid driver's license
- State issued ID
- Valid passport
- School ID
- Consulate ID card
- Birth certificate (age 19 and under only)

Proof of Residency

(Choose 1)

- Current copy of lease agreement
- Current copy of mortgages
- Current copy of utility bill
- Letter from shelter signed by a shelter employee on letterhead
- Letter from nursing home

If you are currently residing in a rehabilitation center or shelter, please provide a dated letter (dated for the day of service), confirming your residency and your employment status.

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Proof of Residency in Georgia
Must be in applicant's name.
Current copy of lease agreement
Current copy of mortgage statement

- Current utility bill (water, electricity or gas only)
- Letter from shelter signed by a shelter employee

Failure to submit the necessary required documentation will delay your application process! If complete documentation is not received within 3 months, your application will be considered abandoned, and you will have to begin the application process over. You must wait 6 months to re-apply.

Patient Rights and Responsibilities

Civil Rights

1. Patients have the right to considerate and respectful treatment in an environment free from harm.
2. Patients seeking services shall not be denied, suspended, or terminated from services or have services reduced for exercising any of their rights.

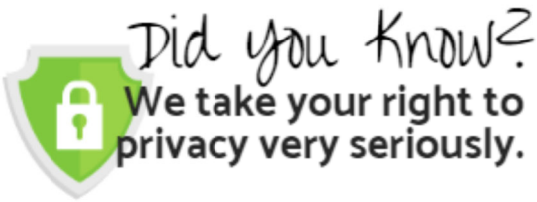
Discrimination

1. Patients have the right to receive services regardless of age, sex, race, creed, color, religion, ethnic origin, ancestry, marital status, physical or mental disability, orientation or identity, veteran status or criminal record.
2. No recipient of services is presumed legally incompetent except as determined by a court.
3. Patients have the right to present any complaint or grievance on matters pertaining to services received, or any perceived or actual violation of rights.

Services

1. A recipient of services shall be provided with adequate and humane care. When appropriate, a recipient's nearest kin or guardian may be involved in the treatment/service

plan. If patient wishes to designate another person to communicate with, he/she must sign the HIPAA waiver ***(Health Insurance Portability and Accountability Act)*** on the application.



2. Patients have the right to know of the variety of services that may be available, and to participate in the planning of treatment.
3. Patients may refuse treatment at any time, and patients have the right to be informed of the consequences resulting from the refusal of treatment.

Privacy/Confidentiality

1. The Lighthouse understands that patient health information is personal and is dedicated to maintaining patient privacy rights under federal and state law. All staff is trained in HIPAA compliance.
2. Patients will receive confidential treatment; all clinical records and client information are protected by law, regulations, and center policies. For the purposes of funding, certification, licensure, audit, research, or other legitimate purpose, your clinical record may be used by the person conducting the review to the extent that is necessary to accomplish the purpose of the review.
3. Patient information released to or requested from other sources requires your written consent. Patient records can be subpoenaed by court order without your signature for release of information.
4. Patients have the right to review and obtain a copy of their clinical record upon request. Processing fees may be applied.

Electronic Health Records

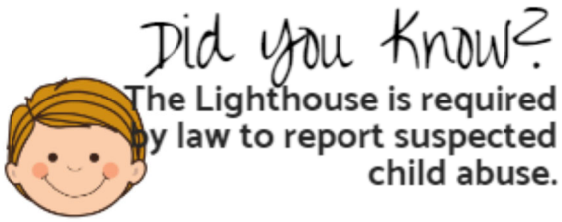
The Lighthouse utilizes an electronic health record system to maintain patient information and to aid in dispensing eyeglasses. This helps to ensure patient and health care providers have access to accurate personal health information. Patients may call to inquire about their own appointments, statuses, and medical information during business hours.

Emergency Procedures

If you have an emergency, you will need to contact police, urgent care, or a hospital depending on your situation.

The Lighthouse Responsibility

1. In the case of suspected child abuse or neglect, The Lighthouse is required by the Abused and Neglected Child Reporting Act to report any suspected incidents of neglect or abuse. The Lighthouse also has the ethical obligation to report suspected maltreatment of senior citizens or adults.



2. If at any time a patient presents a clear and present danger to him- or herself or to others, Lighthouse staff may release information that is required to authorities in order to protect you and/or others.
3. The Lighthouse may restrict or terminate delivery of services to patients who have been evaluated and determined as posing a serious physical threat to staff or others.

Patient Responsibility

1. Patients are expected to complete the application and submit via FAX or mail.
2. Patients are expected to provide accurate and complete information. If your address or phone number changes, please contact us to update your patient profile.
3. Patients are expected to provide accurate and complete information about their health and medical history, as listed on application, and honestly report their health status and conditions to their health care provider.
4. Patients are expected to ask questions when they do not understand information or instructions regarding their exam and/or frame choice.
5. Patients are expected to be considerate and treat all Lighthouse staff, volunteers, other patients, and visitors with courtesy and respect and be mindful of others privacy.
6. Patients are responsible for keeping appointments, and calling The Lighthouse if unable to keep an appointment.
7. Patients are responsible for payment. Each patient is expected to pay for all services rendered at time of service.
8. Communications between client and Lighthouse staff are confidential and will not be revealed unless required by law, such as in situations of child abuse, elder abuse, and or threats of physical harm to self or others.

Patient Policies

Patient Payment and Fee Policy

Patients are required to pay for prescription eyeglasses and any upgrades.

1. Acceptable forms of payment are cash, money order, or credit, debit (Visa or MasterCard). We do not accept personal checks or Discover credit/debit cards.
2. If a patient is unable to make payment for services rendered, he/she may be unable to proceed with the appointment. We do not hold glasses or accept partial payments.

Appointments

1. In the event of inclement weather, please call the clinic or check local television stations for announcements regarding the canceling or delaying of Lighthouse appointments in your area. We typically follow the DeKalb County closing guidelines which will determine if we are able to travel. You can also find updates on our website, www.lionslighthouse.org.

Missed/Cancelled Appointment Policy

1. If a patient is unable to keep a scheduled appointment, he/she must give a **2-day** cancellation notice. This may be done over the phone or in person.
2. If a patient does not cancel an appointment at least two **(2) days** prior, this will be considered a missed or "no-show" appointment.
3. If a patient misses 2 appointments within a year, he/she may be dismissed from the program for 1 year. After that year of dismissal, patient may re-apply for services.

4. Any patient who is a "no-show" for their first appointment will only have one opportunity to be rescheduled (This means they must call to be put back on the end of wait list.) If patient "no-shows" their rescheduled appointment, patient will only be re-enrolled as a patient after 1 year.

Dismissal Policy

Failure to adhere to patient policies may result in dismissal from utilizing services at The Lighthouse. In order to maintain safety, any patient who threatens employees or other patients or compromises The Lighthouse mission may be dismissed from the facility. Behavior justifying dismissal includes but is not limited to that which is abusive or threatening toward self or others; violent language, gestures, or actions; any type of harassment; and chronic failure to keep appointments, pay for services, or adhere to policies as outlined in this patient handbook.

REQUIRED

Lighthouse Statement Please read and sign.

"I fully understand Lighthouse services are limited to residents unable to pay for, or receive from other sources, this assistance. In consideration of these services, I release and discharge all persons rendering such services from any claims I may have arising from the services rendered. I am aware that the Lighthouse will not pay for any eyeglasses billed to me prior to approval of this application. I also understand that my application will be reviewed by a Lighthouse Provider, and/or the Lighthouse staff. ALL INFORMATION ON AND ATTACHED TO THIS APPLICATION IS TRUE AND CORRECT TO THE BEST OF MY KNOWLEDGE."

_____ _____

Signature of Applicant (or parent if applicant is a child) Date

_____ _____

Witness (if applicant signs with an "X") Date

REQUIRED

HIPAA Agreement

I understand that the Federal Privacy Rule ("HIPAA") does protect the privacy of information if re-disclosed, and therefore request that all information obtained by this person or agency be held strictly confidential and not be further released by the recipient. I further understand that my eligibility for Lighthouse services is not conditioned upon my provision of this authorization. I intend for this document to be a valid authorization conforming to all requirements of the Privacy Rule and understand that my authorization will remain in effect for one year.

_____ _____

Signature of Applicant (person applying for services) Date

Complete this portion <u>only</u> if you would like to give us permission to speak with someone else on your behalf regarding your services.

Name:_____ Phone:_____

Relationship to Applicant: _____

Once completed, send your application and copies of all required documents to us by <u>mail</u> or <u>FAX</u>. If you have any questions, please call us at 404-325-3630 and listen to menu prompt.

Application Check-List

The following MUST be submitted for this application to be considered.

Failure to include these documents will delay your application process. Patients are responsible for providing copies of the required documents listed below.

Required Documents

Photo ID (*Provide One*)	**Proof of Residency** (*Provide One*)
☐ Valid driver's license	☐ Current copy of lease agreement
☐ State photo ID	☐ Current copy of mortgage statement
☐ Valid passport	☐ Utility bill (current within 3 months)
☐ Valid school picture ID	☐ Letter from shelter signed by a shelter employee
☐ Consulate ID card	☐ Letter from nursing home
☐ Birth certificate *(for ages 19 and under only)*	

Proof of Income *(Provide One)* *(not required from July 1, 2020-December 31, 2020)*

- ☐ 2 current consecutive paycheck stubs for bi-weekly pay; or 4 current consecutive paycheck stubs for weekly pay
- ☐ Last 3 months of bank statements will only be accepted for SSA or SSI
- ☐ Official tax transcript/Tax Returns 2019
- ☐ Social Security/Disability award letter
- ☐ Non-filing letter from IRS
- ☐ College/university scholarship, grant, fellowship, or assistantship
- ☐ Regular payments from alimony, child support, unemployment, union funds, retirement, or other government programs

Other Required Documents

If you are seeking assistance for eyeglasses only, please attach a copy of your current vision prescription. ***Your prescription must not be more than 2 years old!***

Vision Services Application *(Please print clearly)* ***(COVID-19 Version)***

REQUIRED: Please **check** the box for the services that you are applying for:

☐ Eye Exam and Eyeglasses ☐ Eyeglasses Only

1. Last Name: _____ **First Name**: _____**MI**: _____

2. Address: _____

City: _____ **State:** _____ **Zip Code:** _____

3. County of Residence: _____

4. Home Phone: _____ **Mobile Phone:** _____

5. Email Address: _____

6. Name of Parent or Guardian (if under 18): _____

7. Date of Birth: _____/____ /_____ **10. Gender:** ☐ Male ☐ Female

11. Marital Status: ☐ Single ☐ Married/Partners ☐ Divorced ☐ Separated ☐ Widowed

12. Last four digits of Social Security Number: ____ ____ ____ ____

13. Are you employed? ☐ Y ☐ N

14. If you are unemployed, please provide the reason:

☐ isabled (circle if you receive SSI/SSDI) ☐ Not Able ☐ Retired ☐ Lost Job ☐ Other

15. Race: ☐ White ☐ African American ☐ Hispanic/Latino ☐ Asian ☐ 2 or more Races ☐ Other

16. Primary language: _____

17. Are you a veteran? ☐ Y ☐ N

18. Please select the type of insurance coverage you have:

☐ Medicaid ☐ Medicare ☐ VA ☐ Grady ☐ Private ☐ None

19. Check if you have or have had any of the following:

☐ Glaucoma ☐ Diabetes ☐ Hypertension ☐ Stroke ☐ Cataracts

20. Total Number of People in Household: _____

21. Total Gross Monthly Household Income: $ _____

Please complete ALL questions above in order for the application to be considered complete.

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