Dear Mission Cataract Applicant,

Attached is the application packet that is required for you to be considered as a candidate for our Mission Cataract program. Please be aware that due to the nature of this program, there are very specific financial and medical measures that a candidate must meet in order to be considered, including the Health and Human Services annually published Federal Poverty Guidelines. Please complete all forms included in the application packet and provide all requested information to avoid delay in processing your application or rejection due to lack of required information. If you have any questions regarding the application, please call Ms. Fanstill at 941-480-2143.

The application deadline for Mission Cataract 2020 is Friday, July 31, 2020.
Below is a list of forms included in the Mission Cataract application packet.

Mission Cataract Application
Please complete all four (4) pages of the application **and** enclose copies of financial support documentation with your application. If you have other household members, their tax information is also required.
Examples of financial support documentation include:

1. 2019 Federal tax return
2. Documentation to support that no Federal tax return was required due to lack of income
3. 2019 W2(s) and / or 1099(s) income statements
4. 2019 Social Security retirement or disability income statement (SSA1099)
5. Qualifying documentation for food stamps

Patient Acknowledgement of Mission Cataract Scope of Services
The Patient Acknowledgement of Mission Cataract Scope of Services describes the services covered under the Mission Cataract program. Please review this document, sign and date.

Media Consent Agreement
Center For Sight has created a donor-advised fund of the Gulf Coast Community Foundation to continue our sight saving work for people in need. The non-profit mission of the Center for Sight Foundation is dedicated to providing cataract surgeries for people who don't have insurance or the means to pay for treatment. The Foundation relies on philanthropic gifts from individuals and companies. The Media Consent agreement outlines how your story might be shared to raise awareness about Mission Cataract. Please review this document, sign and date.

Alcon Cares Indigent Patient Surgery Program Application

The Alcon Cares Application allows Center For Sight to work with the Alcon Indigent Patient Surgery Program to provide supplies for Mission Cataract procedures. Please review this document, complete the Patient Information Section, initial the Applicant Declaration, sign and date.

You may mail your completed application packet to:

Center For Sight Foundation
Attention: Vicki Fanstill
1360 East Venice Avenue
Venice, Florida 34285

Or you may fax your completed application packet to: 941-480-2188

REMINDER: The application deadline is Friday, July 31, 2020.

What happens next?

1. When your information is received, your application will be screened for financial qualification.

2. If financially qualified, you will be contacted to schedule a preliminary medical screening with an Optometrist. Medical screenings will begin May 2020.

3. If the results of your medical screening meet the criteria for cataract surgery, you will be contacted again to schedule a consultation with one of our Ophthalmologists. Consultations will begin August 2020.

4. The Ophthalmologist will make the decision for surgery during your consultation. Your surgical appointment, post-operative visits and any additional appointments will be scheduled at this time. Surgeries will begin September 2020.

Due to the number of applications we process for Mission Cataract, we respectfully ask that you do not make repeated calls to ask about the status of your application. You will be notified either by phone or mail as soon as your candidacy is confirmed or rejected.

Thank you for your cooperation
Center For Sight Foundation ~ Team Mission Cataract

MISSION CATARACT APPLICATION

Please complete the following information and attach the required financial documentation to be considered for the Mission Cataract Program. For questions regarding the application, please call 941-480-2143.
All applications must be received by Friday, July 31, 2020.

Applicant Name: _____
Last Name First Name Middle Initial

Social Security Number: _____ Date of Birth: _____

Gender: □ Male □ Female Preferred Language*: _____

Phone Number: _____ Alternate Phone Number: _____

E-Mail Address: _____

Address: _____
Street Address

_____
City State Zip Code

I am: □ U.S. Citizen □ Resident Alien (Green Card) □ Other: _____

Marital Status: □ Divorced □ Married □ Separated □ Single □ Widowed

I am: □ Homeowner □ Renter □ Boarder □ Homeless

Total number of people in my family / household: _____ Please list names and relationships below.

If you need additional space for household members, please attach a separate list. □ See attached list.

_____ □ Spouse □ Child □ Parent □ Roommate □ Other: _____

_____ □ Spouse □ Child □ Parent □ Roommate □ Other: _____

_____ □ Spouse □ Child □ Parent □ Roommate □ Other: _____

I am: □ Employed - Full Time □ Employed - Part Time □ Retired □ Unemployed

If employed, what is your place of employment? _____

If unemployed or retired, what was your occupation? _____

I have: □ No Insurance □ Medicare □ Medicaid □ Other Insurance: _____

How did you hear about Mission Cataract? _____

If referred by a physician, what is the physician's name? _____

Monthly Household Income

What is your monthly income? _____

What is your spouse's monthly income? _____

What is the monthly income of others in your home; not including roommates? _____

Do you receive social security disability? If so, how much? _____

Do you receive a retirement pension? If so, how much? _____

Do you receive any government assistance (i.e. food stamps)? If so, how much? _____

Do you have rental income from real estate? If so, how much? _____

Do you receive any other income from any other source? If so, how much? _____

Do you receive any financial assistance from friends or family? If so, how much? _____

Total Monthly Income _____

Monthly Household Expenses

Rental or Mortgage Payment _____

Food (groceries and restaurants) _____

Clothing _____

Transportation (i.e. car, public, friends, etc.) _____

Utilities (i.e. electric, water, etc.) _____

Medical Expenses including Prescriptions _____

Misc. Expenses (i.e. pet care, loan debt, etc.) _____

Total Monthly Expenses _____

Have you been diagnosed with cataracts by a physician? □ Yes □ No

Have you been diagnosed with any other eye conditions or diseases? □ Yes □ No

If Yes, please explain. _____

Do you wear glasses or contact lenses? □ Yes □ No

When was your last eye exam? _____

What is the name of the physician that performed your eye exam? _____

How bad is your vision today? What do you have the most difficulty seeing or doing?

_____

_____

_____

_____

When did you first realize that you were having difficulty seeing?

_____

_____

_____

_____

How is your poor vision affecting your quality of life? (i.e. work, hobbies, etc.)

_____

_____

_____

_____

Do you use any visual aides to assist you in your daily routine? □ Yes □ No

If Yes, please explain. _____

_____

_____

What are some of the things you are excited to do when your vision is restored, and you can see better again?

How do you feel about Center For Sight donating free cataract surgery?

Would you be willing to share your story to help raise awareness about Mission Cataract? ☐ Yes ☐ No

I have attached the following financial support documentation with my application.

☐ 2019 Federal tax return

☐ Documentation to support that no Federal tax return was required due to lack of income

☐ 2019 W2(s) and / or 1099(s) income statements

☐ 2019 Social Security retirement or disability income statement (SSA1099)

☐ Qualifying documentation for food stamps

☐ Other: _____

Reminder: Financial documentation **must** be included with your application in order to be considered for Mission Cataract.

I confirm that the information provided is complete and accurate to the best of my knowledge.

***If English is not my primary language, I certify that I will bring a translator with me to all visits including my surgical appointments.**

Signature: _____ Date: _____

US EYE | CENTER FOR SIGHT

PATIENT ACKNOWLEDGEMENT OF SCOPE OF MISSION CATARACT SERVICES

Center For Sight is proud to support and participate with Mission Cataract and remains committed to our annual effort to restore sight for patients who might not otherwise have the means to pay for cataract surgery.

Center For Sight donates the time and expertise of the surgeons, optometrist, nurses, technicians and other support staff as well as the use of its state-of-the-art facility for all surgeries. Each year, Center For Sight donates more than 1,000 man-hours to this vital program.

The Center For Sight Foundation donates funds to acquire intraocular lens implants, medications, surgical supplies and post-operative glasses for Mission Cataract patients, so there is absolutely no cost to patients.

Just as financial candidacy for this program is determined by the Federal Poverty guidelines as issued by the Department of Health and Human Services, so the medical services are rendered in accordance with federal Medicare guidelines. Following those guidelines, Mission Cataract provides for manual cataract surgery with a standard intraocular lens implant and 90-day post-operative care directly related to the surgical procedure(s).

Mission Cataract does not include laser cataract surgery or advanced lenses which are not covered under Medicare guidelines. Medical care unrelated to the cataract surgery(ies) provided is not considered part of the Mission Cataract program.

Following cataract surgery, a YAG procedure may be recommended to correct blurring of vision which occurs due to a natural progressive cloudiness of the capsule into which the standard intraocular lens is placed. This procedure, if recommended, would be covered under the Mission Cataract program within the same calendar year of the cataract surgery. Outside of that period a financial application must be completed to reconfirm candidacy for the Mission Cataract program.

By my signature below, I acknowledge my understanding of the services, and limitations thereof, for the cataract surgery(ies) that I will receive at no charge to me through Mission Cataract.

Patient Name (printed): _____

Patient Signature: _____ Date: _____

MEDIA CONSENT AGREEMENT

Entered into this _____ day of _____, 2020, by and between
(enter date) (enter month)

_____ (hereinafter referred to as the Subject)
(print name)

and Center For Sight.

I hereby grant Center For Sight the right to photograph or videotape me with the intent to use for media relations, social media, press coverage, publicity, education, advertising and other promotions via brochures, posters, picture murals, website, press releases, videotapes, film and text and any other written or digital purposes.

NOW THEREFORE, it is agreed by the parties hereto as follows:

1. Subject consents to the use of handwritten testimonials, videotapes, photographs, interviews, direct and indirect quotes and/or likeness of Subject made or hereinafter to be made by Center For Sight or representatives thereof, alone or with others, obtained while either on or off Center For Sight premises and affiliated offices and facilities.

2. Center For Sight agrees that said videotapes, photographs, interviews, direct and indirect quotes and/or likeness of Subject will be used solely in the interest of positive representations of Center For Sight and/or Subject and only for the purpose of media relations, social media, press coverage, publicity, entertainment, education, advertising, and other promotions via brochures, posters, picture murals, website, press releases, videotapes, film and text, as well as any other written or digital purposes.

3. Subject agrees that Center For Sight is to be the sole owner of all rights and copyright holder of the videotapes, photographs, interviews, content about, direct and indirect quotes and/or likeness of Subject for all purposes set forth herein.

4. Subject understands that he/she shall receive no financial compensation or any form of remuneration for the use of videotapes, photographs, interviews, content about, direct and indirect quotes and/or likeness of Subject.

5. Subject further understands that Center For Sight has no control over the subsequent use of said videotapes, photographs, interviews, content about, direct and indirect quotes, and/or likeness of Subject and text by other parties after it has been published or used by Center For Sight via social media, brochures, posters, picture murals, website, press releases, videotapes, film, text and any other written or digital purpose.

IN WITNESS WHEREOF, the parties have executed this agreement on the month, day and year specified above.

_____ _____

Subject's Signature Date

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

Indigent Patient Surgery Program Application

AlconCares™

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):

_____

_____