



2855 Gramercy - Houston, Texas 77025
Phone (713) 558-8760 Fax (713) 668-3823
www.houstoneye.com/foundation

ABOUT THE FOUNDATION

In 1981, the Houston Eye Associates Foundation (HEAF) was formed as a 501(c)(3) non-profit organization by a group of Houston Eye Associates ophthalmologists. The physicians focused on restoring sight or preventing blindness by providing necessary medical eye surgery and services to those that could not receive assistance elsewhere (through county or government programs.) The physicians donate their office time and surgical skills while the HEAF pays for surgery center fees, medications and ancillary expenses for *qualified* patients. HEAF assistance must be renewed on an annual basis.

ONLY NEED GLASSES OR AN EYE EXAM?

For those in need of low-cost eye exams and discounted glasses, call University of Houston Good Neighbor Clinic at (713) 527-8480. For those needing eyeglasses, please call The Lion's Club at (713) 796-2960 or Prevent Blindness Texas at (713) 526-2559.

WHO QUALIFIES: To qualify for HEA Foundation assistance, the following conditions must be met:

- a) Applicant must not have any type of medical insurance, private or through the government.
- b) Applicant must have applied and show proof of denial from government medical assistance programs such as the **Medicare/Medicaid** programs.
 - If applicant is over 65, a denial letter from **Medicare** must be included with this application. Call 1-800-772-1213 or 866-539-5598 to begin the Medicare process.
 - If applicant is 18 and under, a denial letter from **Medicaid** must be included with this application. Call 1-800-252-8263 or 800-925-9126 to begin the Medicaid process.
 - All children in Texas age 18 and under, are eligible for affordable insurance through a program called the TexCare Partnership/CHIP. To apply call 1-800-647-6558, or go online: Texcarepartnership.com.
- c) Applicant must have applied and show proof of **denied county medical assistance** in the residing county.

Angelina County	936-634-5431	Harris County. Gold Card	713-566-6691
Brazoria County	979-864-1884	Liberty	936-336-4693
Chambers County	409-267-8306	Matagorda County	979-245-8421
Colorado County	979-732-9453	Montgomery County	936-523-5100
Fort Bend County	281-341-6624	Orange County	409-882-7838
Galveston County	409-770-5550	San Jacinto	936-653-2091
Jasper County	512-458-7706	Trinity	936-642-1736
Jefferson County	409-835-8530/409-983-8380	Waller	979-826-7730
Hardin	409-246-5189	Wharton	979-532-5637

TO APPLY

Complete HEA Foundation application and send with the following documents:

- Denial letter from residing county indigent program
- Denial letter from Medicaid/Medicare program
- Copy of household 2010 1040 tax return. If tax return is unavailable, send proof of income, such as a W-2 or a handwritten letter from employer confirming income. If unemployed or living with family members, send proof of household income for the family.
- Copy of the last paystub that includes year to date figures for all working individuals in the household, and if applicable, a copy of any financial award letters from disability, social security, unemployment offices.



Please print clearly in ink and return with the required paperwork to:
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Name of Patient _____ Date: _____
(First Name Last Name)

Are you a current HEA Foundation patient? _____

Name of Parent (if patient is under 18)

Who referred you to HEAF? _____ Who is your physician? _____

For what type of medical eye problem are you seeking help? _____

Birth Date _____ Social Security Number _____ Home Phone _____ Work Phone _____ Cell Phone _____

Address _____
City State Zip

Total number of persons in household _____ Number of wage earners in household _____ Yearly household income _____ County of residence _____

Optional: Anglo African-American Latin Asian Other Male Female

PLEASE ANSWER YES OR NO:

1. Do you have health insurance? _____
2. Do you have Medicare? _____ Do you have Medicaid? _____ If NO, have you applied for it? _____
3. Do you have county medical assistance? _____ If NO, have you applied previously? _____
4. Are you currently employed? _____ If NO, is your unemployment due to vision issues? _____

**Please submit the following documents along with this completed application:
Do not send originals. HEAF office will not photocopy and return submitted documents.**

- Denial letter from residing county indigent program.
- Denial letter from Medicaid/Medicare program, if applicable.
- Copy of household 2010 1040 tax return. If tax return is unavailable, send proof of income, such as a W-2 or a handwritten letter from employer. If unemployed and living with family members, send proof of household income for the family.
- Copy of the last paystub that includes year to date figures for all working individuals in the household, and if applicable, a copy of any financial award letters from disability, social security, unemployment offices.

Your Employer _____ Position _____ Yearly gross income _____

Spouse's Employer (If applicable) _____ Position _____ Yearly gross income _____

Please list the amount of your monthly expenses: Rent/Mortgage _____ Electricity _____
Telephone _____ Food _____ Car _____ Child Support (if applicable) _____

Sign here stating the information you have provided above is true: _____