EMERGENCY EYE CARE PROGRAM
FINANCIAL ELIGIBILITY FORM
Fax to (505) 272-6125

PATIENT NAME:	DATE: / / 20
SOCIAL SECURITY #: - -	MR #:
	TOTAL HOUSEHOLD INCOME: $

All information is confidential and will only be used in this office.

PATIENT INFORMATION		
Name:	SS #: - -	DOB: / /
Address:	Phone #: ( ) -	Number in Household:
City , State, Zip:	Cell #: ( ) -	Ethnicity:
County:		Relationship to Patient:
Employer:	Gross Wages: $	☐ Weekly ☐ Bi-weekly ☐ Semi-monthly ☐ Monthly
Social Security: $	SSI: $	Unemployment, Alimony, Trust Fund, etc.: $
Other Sources of Income: $		

OTHER HOUSEHOLD MEMBER INFORMATION		
Name:	SS #: - -	DOB: / /
Cell #: ( ) -		Relationship to Patient:
Employer:	Gross Wages: $	☐ Weekly ☐ Bi-weekly ☐ Semi-monthly ☐ Monthly
Social Security: $	SSI: $	Unemployment, Alimony, Trust Fund, etc.: $
Other Sources of Income: $		

The applicant will be relied upon as a primary source of information about the wages he/she has reported to be truthful. Verification of information is necessary to confirm the accuracy of the information.

I _____, certify that all of the information I have provided to the eye care provider in regards to my financial situation is correct and true. I also certify that I am not covered by any health insurance plan but have applied or I will sign up within the next 2 months.

Signature: _____ Date: / / 20