

## THE SHEPHERD'S TABLE EYE CLINIC ELIGIBILITY SCREENING FORM

Agency's Address			orker/Screener		
Agency 3 Address					
Telephone	Ext: _		DATE: _	//	_
Name:					
(Las	st)	(First)		(Middle)	
Date of Birth/_	/	Social Securit	y Number:		
Current Address:					
(nı	ımber) (	(street)			
				Gender: Male	☐ Female ☐
(cit	cy) (state)	(zip code)			
Telephone (home)		(Other)		Race:	
Medical Insurance (M	IEDICARE) or Medical As	ssistance?		Disability: Y	es 🗆 No 🗆
Does your Medical in	surance cover eye care?	Yes 🗆 No 🗆			
Are you in a Manage	Care Organization (MCC	D)? Yes □ No □ U	Jnited Health Car	re 🗖 Physician's (	Care 🗆 Other 🗆
Have you had Catara	ct Surgery in the past? Y	es 🗆 No 🗆			
	the Household, includin	g yourself:	_ Female Headed	d Household? Yes	□ No □
Number of people in					
		Number of Mo	iitiis) i cais iii tiic		
Country of Origin:	onthly Income: (every m				
Country of Origin: Household's Total Mo		ember's income, inc	luding wages and	d child support, u	
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## **Submit this form to:**

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