N.C. DEPARTMENT OF HEALTH AND HUMAN SERVICES
DIVISION OF SERVICES FOR THE BLIND
MEDICAL EYE CARE PROGRAM

APPLICATION FOR EYE CARE CERTIFICATION

Your answers to the questions below will determine if you are eligible for eye care services to be paid for by the North Carolina Division of Services for the Blind.

Name _____ _____ _____ _____ _____
(Last) (First) (Middle/Maiden) (SSN #) (Phone #)

Address _____ _____ _____ _____
(Street) (City) (Zip Code) (County)

Date of Birth _____ Sex _____ Marital Status _____
(MM/DD/YY)

Race Caucasian or White ☐ Black or African American ☐ Asian ☐ Native American or Alaska Native ☐
Native Hawaiian or Pacific Islander ☐

Ethnicity: Hispanic/ Latino Yes ☐ No ☐

Language Preference: _____ United States Citizen Yes ☐ No ☐

Is applicant eligible for other federal and state programs that purchase eye care services, including the Division of Vocational Rehabilitation or School Health? Yes ☐ No ☐

Is applicant receiving MQB? Yes ☐ No ☐

Is applicant receiving MEDICAID? Yes ☐ No ☐

Is applicant applying for MEDICAID? Yes ☐ No ☐

Is applicant receiving MEDICARE or Medicare Advantage Plan? Yes ☐ No ☐

MEDICARE # _____ Type: _____

Is applicant applying for MEDICARE? Yes ☐ No ☐

Does applicant have other medical or hospital insurance? Yes ☐ No ☐

If yes, list Company & Policy # _____

If a person has medical insurance coverage, including Medicare A, B, C (Advantage Plans), and D they are not eligible for the Medical Eye Care Program when their insurance covers the needed eye-related services. The individual is responsible for the deductible, co-insurance, and co-payments required by their medical policy. Please provide a copy of the card(s).

Are you presently employed? Yes ☐ No ☐

Are you interested in obtaining employment? Yes ☐ No ☐

If yes, refer to _____ district office.

How does your visual impairment affect your daily life?

☐ Cannot read ☐ Cannot travel independently ☐ Cannot drive ☐ Cannot prepare a meal
☐ Cannot care for my family ☐ Cannot Work ☐ Other ☐ It has not affected my life

If you do not obtain services, will you be in danger of becoming unemployed?
(If client says they are employed) Yes ☐ No ☐

List below all members of your family in the household related by blood or marriage and provide all of the requested information about each person. Definition of family is in section 200 of the Medical Eye Care Manual.

Name	Age	Relationship to Applicant	Social Security #	Where Employed/ What Grade in School	Amount of All Income	How Often Received

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List additional family members and the requested information as well as other relevant information & record on back if needed:

INCOME FOR FAMILY UNIT

Sources	Amount	How Often Received	Documentation
Gross Wages Total earned income before deductions.....			
Social Security/ Disability.....			
Pensions VA, other retirement/ pensions.....			
Workmen's Compensation.....			
Unemployment Benefits.....			
Court Ordered Child Support.....			
Interest/ Dividends Interest must be counted even if it added to account and immediate payment is not taken.....			
Self Employment/ Farm Income.....			
Support from Family/ Friends.....			
Other (i.e. alimony).....			
Total Monthly Income.....			

ITEMIZED DEDUCTIONS - FAMILY UNIT

	Amount of Deduction	How Often Deducted/ Expended
Payroll Deductions Federal Income Taxes.....		
State Income Taxes.....		
Social Security (FICA).....		
Medicare Taxes.....		
Total Monthly Deductions.....		

Applicant must present proof of income and deductions for the six months preceding the date of application.

TOTAL MONTHLY INCOME - TOTAL MONTHLY DEDUCTIONS = _____ NET INCOME

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FREEDOM OF CHOICE STATEMENT

You have the right to receive eye services by an eye care provider of your choosing who accepts payment from the Division of Services for the Blind. The eye services will be paid for by the Division of Services for the Blind if you have been determined eligible for this Program. I would like services provided by:

_____

Name & Address of Eye Care Provider

INFORMATION TO BE READ BY A/R OR READ TO A/R BY INTERVIEWER

Information on this form will be treated confidentially as provided by G.S. 111-28. This agency operates under Title VI of the Civil Rights Act of 1964.

G.S. 111-23. Misrepresentation or fraud in obtaining assistance: Any person who shall obtain, or attempt to obtain, by means of a willful, false statement or representation, or impersonation, or other fraudulent devices, assistance to which he is not entitled shall be guilty of a misdemeanor and upon conviction shall be punished by a fine of not more than five hundred dollars ($500.00), or by imprisonment in the county jail for not more than three months, or both such fine and imprisonment.

When you have completed all the information including written proof of your income and deductions, return this form to your county Department of Social Services or to the office of the person who interviewed you by phone or in person. You will be provided notice of the decision on your eligibility for eye care services.

Under the penalty of law, I certify that the information in this application is correct. If necessary, I authorize an investigation as to the correctness of this information.

We will contact you within 30 days of your date of service to conduct a follow-up interview.

Signed _____ Date _____

Witness _____ _____
(When person signs with "X") (Signature of parent or guardian if person needing eye care is a minor.)

I certify that the information in this application has been verified.

Signed _____ _____ _____
Interviewer (Person taking application) Title Phone #

☐ **Offered Voter Registration Services**

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FOLLOW UP QUESTIONS:

How have MEC services affected your vision and your life?

☐ Can read ☐ Can travel independently ☐ Can drive ☐ Can prepare a meal ☐ Can care for my family
☐ Can work ☐ Other ☐ It has not affected my life

Do you work? ☐ Yes ☐ No

Has your vision improved or were you able to avoid blindness? ☐ Yes ☐ No ☐ Attempted but unsuccessful

Were you helped by MEC services? How?