CookChildren's

Alexander Vision Center/Eye Clinic

- The Alexander Vision Center provides **routine eye examinations and eye glasses, if needed at no cost** for children residing in North Central Texas. This service is for children who do not have medical insurance that covers the cost of a vision exam and/or eye glasses. In addition, families must meet the Federal Register 150% Poverty Income Guidelines.

- Referrals made to our clinic usually come from school nurses, physician's offices or public health agencies. Appropriate referrals for the Eye Clinic are children age 3 to 16, who have failed a vision screening at school, doctor's office/clinic or at another screening event. Also appropriate are children who have obvious strabismus; turning in or out of an eye or any other apparent vision abnormality (please call if in doubt).

- Families are required to complete an application for screening and treatment. In addition, families must meet the Federal Register 150% Poverty Income Guidelines. Please complete the "Referred By" and acuity sections near the bottom of the form. We need the name of the person referring the patient; the name of school, doctor's office/clinic or health facility, phone number and acuities. We also need signatures of the parent and person/nurse/doctor referring this student. ***Applications may not be processed without this information.***

- Families that qualify for our clinic will receive a letter from our office two weeks prior to the date of that appointment. This letter will give them specific information including date, time and address of the appointment. We are currently able to schedule appointments within one month of application.

- ***Medicaid Patients** - Children covered for vision care services by Medicaid or private insurance are not seen in the Cook Children's Eye Clinic. Our physicians prefer to see these patients in their private practice. Most patients will need to obtain a referral from the child's primary Medicaid physician. It is suggested that families on Medicaid refer to the telephone number on the child's Medicaid card to obtain information on vision care coverage and a list of available optometrists or ophthalmologists.

  Do not hesitate to contact us for assistance, questions, referrals or concerns. Please contact Olga Uriegas, Director of Alexander Vision Center Eye Clinic at olga.uriegas@cookchildrens.org or by phone at 682-885-4499.

~ ~

CookChildren's

Alexander Vision Center Eye Clinic Income Guidelines

(Federal Register Chart for 150% of the HHS Poverty Guidelines)

Total # of Family Members	Maximum Gross Monthly Income
1	$1,517.50
2	$2,057.50
3	$2,597.50
4	$3,137.50
5	$3,677.50
6	$4,217.50
7	$4,757.50
8	$5,297.50
+ additional	Add $540.00

Guidelines set per Federal Poverty Guidelines (Federal Register)
Chart for 150% of the HHS Poverty Guidelines https://aspe.hhs.gov/poverty-guidelines
150% of the HHS Poverty Guidelines for 2018
http://www.uscourts.gov/sites/default/files/poverty-guidelines.pdf

Alexander Vision Center/Eye Clinic ◆ 321 S. Henderson Street ◆ Fort Worth, TX 76104 ◆ 682-885-4499

CookChildren's
Medical Center

2019 ALEXANDER VISION EYE CENTER EYE CLINIC APPLICATION

Children covered for vision care services by private insurance or Medicaid are not seen in the Cook Children's Eye Clinic. is suggested that families refer to the telephone number on the child's insurance card to obtain information on vision care coverage and a list of available optometrists or ophthalmologists.

PLEASE DO NOT COMPLETE THIS FORM IF YOUR CHILD HAS INSURANCE OR MEDICAID.

PATIENT'S NAME _____

DATE OF BIRTH _____ SEX _____

FATHER'S NAME _____ BIRTHDATE _____

MOTHER'S NAME _____ BIRTHDATE _____

ADDRESS _____ APT# _____

CITY _____, TEXAS ZIP CODE _____

HOME PHONE _____ OTHER PHONE # _____

PARENTS' EMAIL ADDRESS _____

INCOME: (LIST MONTHLY INCOME BEFORE TAXES)

FATHER'S EMPLOYER _____ PHONE # _____ ***MONTHLY*** SALARY _____

MOTHER'S EMPLOYER _____ PHONE # _____ ***MONTHLY*** SALARY _____

Other Salary _____

WHAT IS YOUR CHILD'S VISION PROBLEM? _____

HAS YOUR CHILD BEEN A PATIENT AT THE EYE CLINIC BEFORE? _____ IF SO, WHEN? _____

HAS YOUR CHILD HAD EYE CARE AT ANY LOCATION? _____ IF SO, WHERE? _____

WHO IS YOUR CHILD'S DOCTOR? _____ NAME OF ANY DOCTOR VISITED RECENTLY _____

WHO REFERRED YOU TO THE CLINIC? NAME: _____ TITLE _____

SCHOOL OR OTHER AGENCY _____

THIS PERSON'S EMAIL _____

REFERRAL PHONE# _____ CHILD'S ACUITY AT SCREENING _____ RIGHT _____ LEFT

OTHER CONCERNS: _____

FOR CLINIC USE ONLY

DATE RECEIVED: _____
SCREENED BY: _____
APPROVED: _____ DENIED: _____

****SIGNATURE OF PARENT/GUARDIAN and NURSE**

_____

_____

*Children covered for vision care services by private insurance or Medicaid are not seen in this Cook Children's Eye Clinic.

MAIL/FAX or SCAN TO: COOK CHILDREN'S EYE CLINIC • 321 S. HENDERSON ST. • FORT WORTH, TEXAS 76104
PHONE (682) 885-4499 • FAX (817) 882-8992

CookChildren's
Medical Center

2019 ALEXANDER VISION CENTER APLICACION DE LA CLINICA OPTICA

Por Favor no complete esta forma si tiene azugaranza/seguro o Medicaid para su hijo.

NOMBRE DEL PACIENTE_____

FECHA DE NACIEMENTO_____ SEXO _____

NOMBRE DEL PADRE_____FECHA DE NACIEMENTO _____

NOMBRE DE LA MADRE_____FECHA DE NACIEMENTO _____

DOMICILIO_____APT#_____

CUIDAD_____TEXAS ZONA POSTAL _____

TELEFONO_____ de AMIGO/CONOCIDO_____

EMAIL_____

DEPENDIENTES: (NO INCLUYA LOS NOMBRES MENCIONADOS ARRIBA)

NOMBRE_____EDAD_____SEXO_____ NOMBRE_____EDAD_____SEXO_____

NOMBRE_____EDAD_____SEXO_____ NOMBRE_____EDAD_____SEXO_____

NOMBRE_____EDAD_____SEXO_____ NOMBRE_____EDAD_____SEXO_____

INGRESO: (INCLUYA EL INGRESO MENSUAL ANTES DE DEDUCCIONES)

TRABAJO DEL PADRE_____TELEFONO_____SALARIO ***MENSUAL*** _____

TRABAJO DE LA MADRE_____TELEFONO_____SALARIO ***MENSUAL*** _____

¿CUAL ES EL PROBLEMA OPTICO DE SU NIÑO? _____

¿HA SIDO SU NIÑO UN PACIENTE DE LA CLINICA OPTICA ANTERIORMENTE? _____¿FECHA? _____

¿HA VISITADO SU NIÑO A UNA CLINICA OPTICA ANTERIORMENTE?_____ ¿DONDE?_____¿QUIEN ES EL

¿QUIEN LE RECOMENDO A LA CLINICA? NOMBRE:_____**TITILO** _____

NOMBRE DE ESCUELA/AGENCIA_____

EMAIL DE QUIEN LE RECOMENDO _____

NUMERO DE TELEFONO_____

AGUDEZA DEL NIÑO AL EXAMINAR_____ DERECHA _____ IZQUIERDA _____

SOLO PARA USO CLINICO

FECHA RECIBIDO:_____
EXAMINADO POR:_____
APROBADO:_____ NEGADO: _____

****FIRMA DEL PADRE/TUTOR Y ENFERMERA/CLINCA**

_____

_____

Por Favor no complete esta forma si tiene azugaranza/seguro o Medicaid para su hijo.

MANDE POR FAX O EL CORREO A: COOK CHILDREN'S EYE CLINIC • 321 S. HENDERSON ST. • FORT WORTH, TEXAS 76104
PHONE (682)885-4499 • FAX (817) 882-8992