Mark D. Emig, MD
Comprehensive Ophthalmology, Diseases and Surgery of the Retina

Teri K. Geist, OD
Comprehensive Optometry

Scott L. Greder, OD
Comprehensive Optometry

Martin W. Mizener, MD
Comprehensive Ophthalmology, Glaucoma and Cataract Surgery

Mindy J. Dickinson, OD
Comprehensive Optometry

David D. Ingvoldstad, MD
Comprehensive Ophthalmology, Diseases and Surgery of the Retina

Jill J. Grennan, MD
Comprehensive Ophthalmology and Cataract Surgery

Abigail A. Jackson, OD
Comprehensive Optometry

Michael R. Feilmeier, MD
Comprehensive Ophthalmology, Corneal and Cataract Surgery

Krystal A. Wells, OD
Comprehensive Optometry

Matthew L. Willis, OD
Comprehensive Optometry

Matthew F. Appenzeller, MD
Comprehensive Ophthalmology, Diseases and Surgery of the Retina

Rachel C. Mercer, MD
Comprehensive Ophthalmology and Cataract Surgery

Jesse T. Himebaugh, MD
Comprehensive Ophthalmology, Corneal and Cataract Surgery

Zachary W. Brown, OD
Comprehensive Optometry

Bliss E. O'Bryhim, MD, PhD
Comprehensive Ophthalmology, Diseases and Surgery of the Retina

Madeline D. Ripa, MD
Comprehensive Ophthalmology, Corneal and Cataract Surgery

Kristen N. Green, OD
Comprehensive Optometry

Gregory E. Haskins, MD
Comprehensive Ophthalmology and Cataract Surgery

Steven W. Samuelson, MD
Comprehensive Ophthalmology

Patricia A. Terp, MD
Comprehensive Ophthalmology and Cataract Surgery

Other metro locations:
13500 California Street
Omaha, NE 68154

715 Harmony, Suite 300
Council Bluffs, IA 51503

7202 Giles Road, Suite 3
La Vista, NE 68128

18111 Q Street
Omaha, NE 68135

2827 N Clarkson Street
Fremont, NE 68025

Midwest Eye Care, PC
4353 Dodge Street
Omaha, NE 68131
402-552-2020
Facsimile 402-552-2367
www.midwesteyecare.com

July 25, 2022

Midwest Eye Care is now accepting applications for the 2022 **Mission Cataract USA**, a national program that originated in California in 1991. Candidates will be screened, by appointment only, to identify those people with cataracts and significant financial need. We will perform up to twenty-five free cataract surgeries at Midwest Eye Surgery Center, with selection based on financial need and the severity of their cataracts. The entire process is free to qualified patients; there are no charges for the exam, pre-op tests, surgeon, facility or anesthesia.

In order to determine if you are a candidate for this program, we have attached six separate forms (also available at https://www.midwesteyecare.com/mission-cataract/) that need to be completed and sent back to Midwest Eye Care by **Friday, September 9, 2022**. We will also need you to submit copies of your 2021 W-2 and your last two pay stubs. If you are currently unemployed, we need proof of any type of income, such as welfare, food stamps, or social security disability. Please make sure all paperwork is returned by the deadline as this will help ensure you move on to the next step of the process.

If you have not already done so, we will also need you to apply for Medicaid. If you have not applied for Medicaid in the past 3 months, Nebraska residents will need to call 402.595.3400, or visit the Nebraska Department of Health and Human Services on the 3rd floor at 1313 Farnam, Omaha, Nebraska. For candidates living in Iowa, you can either apply online at dhsservices.iowa.gov or call their help center at 1-855-889-7985. This will need to be done right away as we will need proof that you have either applied for Medicaid or have been denied coverage. Please make sure to keep all paperwork and send with your forms.

We have included a self-addressed and postage paid envelope, so there is no need to add a stamp. If you have any questions, please call 402/552-2020 to speak with a Mission Cataract Coordinator. Please make sure to return the required paperwork by the September 9, 2022 deadline.

Sincerely,

Jay Slagle
CFO

Mission Cataract Application Process

July 2022	Application period begins. Information distributed to religious institutions, non-profit agencies and media outlets.
September 9, 2022	Deadline to return Forms 1 through 6 in the attached packet, as well as supporting documents listed on those forms. This is the financial screening portion of the application process. If your financial information is approved, you will be provided with an appointment for a screening exam.
September 2022	Screening exams will be performed on the same day for all candidates. If you are not available on the screening date, your application will be considered in 2022. We will examine up to 50 patients on the screening date, and approximately 25 patients will be selected for free surgery. In general, patients will be selected based on the severity of their cataracts.
October 10, 2022	By this date, all candidates selected for free cataract surgery will be contacted by phone to schedule a surgery date. The candidates not selected for surgery will be notified by mail.
October 2022	Patients selected for surgery will be scheduled for pre-op tests with Midwest Eye Care. They will also be scheduled for a pre-op history and physical exam with Clarkson Family Medicine to confirm that they are healthy enough to undergo surgery.
October 2022	Surgery will be performed on several dates in October.
Oct/Nov 2022	Surgical patients will have a post-op exam with a Midwest Eye Care doctor on the day after the surgery and approximately two weeks after surgery. Most patients are released from care after two or three post-op appointments.
April 2023	The application process for Mission Cataract 2023 will begin.

Form 1

Mission Cataract Initial Questions

Key questions to answer before you complete any additional paperwork:

1. Was your 2021 household income above the limits in the chart below?

# in household	1	2	3	4	5	6
Limit *	$25,520	$34,480	$43,440	$52,400	$61,360	$70,320

   Add $8,960 for each additional member of the household above 6 persons.

2. Do you have health insurance coverage with a deductible of $3,000 or less?

3. Do you have Medicare, Medicaid or another state or federal health plan?

4. Do you have any of the following signficant health conditions?
   a. Have you had a heart attack (myocardial infarction) in the last 365 days?
   b. Have you had a heart procedure in the last 365 days, such as angioplasty surgery with or without a stent, coronary bypass surgery, or another open heart surgery?
   c. Uncontrolled blood pressure?
   d. Uncontrolled blood sugar levels?
   e. Major surgery for any reason in the last 180 days? If so, what type of surgery:
      Surgery explanation: _____

If you answered 'yes' to any of these questions, you will not be selected for the Mission Cataract program this year. We recommmend that you do not submit an application for this year's program.

Patient attestation:
I confirm that that my household income is below the amount listed above, my health insurance coverage (if any) has a deductible of more than $3,000, I do not have state or federal health insurance coverage, and I do not have any of the significant health conditions listed above:

_____ _____ _____
Patient signature Patient name Date

_____
Address, city, state, zip

_____ _____
Your phone number(s) Your e-mail address

In case we are not able to reach you with the above contact information, please provide us with the contact information for someone who will know how to find you:

_____ _____
Emergency contact name Emergency contact phone number(s)

Form 2

Mission Cataract Patient Responsibilities

1. I will make sure to answer every question on the required financial forms and also to return all of the required paperwork. ***All paperwork must be returned by September 9, 2022.***
    - Last W-2s for adults in household
    - Last 2 pay stubs for adults in household
    - Photo I.D. of applicant
    - Copy of monthly bills
    - Copy of insurance card for high-deductible plan
    - Copy of Medicaid denial
    - A working phone number in which to contact patient.
    - Power of attorney documentation (if you are filling out forms on behalf of someone else)
    - Communication Form
2. I will inform Midwest Eye Care P.C. of my designated spoken language.
3. I will provide complete and accurate information about past illnesses and surgeries. Along with a list of all medication currently being taken. For example:
    - Non-prescription medication.
    - Current medication prescribed by any other doctor.
    - Allergies
4. I will make transportation arrangements for the day of the evaluation and for the following additional appointments.
    - Pre-op tests. (Pre-op tests may be done the day of the evaluation)
    - History and physical. (Surgery may be cancelled without this paperwork)
    - Surgery day.
    - All post op appointments.
5. If contact lenses are worn – I understand I am required to be out of them for 2 weeks prior to evaluation.
6. I am required to have a responsible adult to transport and stay with me the day of surgery, listen to instructions, transport me home after surgery and ensure drops are being used as instructed.
7. I will arrive at surgery center day of surgery, on instructed day and time. I understand arrival delays may result in surgery cancellation.
8. I have a clear understanding that the surgery date is a set date and cannot be adjusted.
9. I have a clear understanding that if I miss any of the scheduled appointment dates prior to surgery that my surgery will be cancelled and I will have to reapply next year.
10. I will behave respectfully towards the healthcare professionals, staff and other patients.

I have reviewed and agree to the above patient responsibilities for Mission Cataract.

_____ _____

Patient Signature Date

Form 3

AUTHORIZATION FOR RELEASE OF INFORMATION

For Media/Public Relations and Marketing Purposes

This signed consent confirms your agreement by which Midwest Eye Care, P.C. and/or Midwest Eye Surgery Center, LLC has the right to use your information for the purpose of public relations, which includes the following: (1.) Your personal information, whole or in part, regarding treatment, services received, products, customer service, or any other appropriate comments, and (2.) Your first name, last initial, and city and state in which you live and phone number if needed. You hereby agree as follows:

1. You hereby grant Midwest Eye Care, P.C. and/or Midwest Eye Surgery Center, LLC the right to use the testimonials.
2. The information (excluding your phone number) may appear in connection with (1) the business website, www.midwesteyecare.com, (2) publications for business related to advertising, marketing, information and education, or any other publication deemed useful and appropriate by the company, and (3) all electronic and print media (video, pamphlets, mailings, Facebook, newspapers, etc.)
3. You hereby agree that you are over the age of 18 years old.
4. You hereby waive all rights and release Midwest Eye Care, P.C. and Midwest Eye Surgery Center, LLC to use and utilize your testimonial.

By signing this consent form, you are acknowledging your consent to the terms noted above.

_____ _____

Print Name Date

_____

Signature

Financial Worksheet

PATIENT INFORMATION

DATE: _____

Patient Name: _____ Account #: _____

Are you?

_____ Married
_____ Widowed
_____ Single
_____ Separated
_____ Divorced

_____ Homeowner
_____ Renter
_____ Farm owner
_____ No stable home
_____ Nursing home

_____ Retired
_____ Employed
_____ Unemployed

Do you have health insurance?
_____ Yes _____ No
Insurer name: _____
Policy number: _____
Annual deductible: _____

RESPONSIBLE PARTY

PLEASE INCLUDE YOUR LAST TAX RETURN AND YOUR LAST 2 PAY STUBS.

Name: _____
Social Security #: _____
Home Phone #: _____
Marital Status: _____
Age Dependent Children: _____

Employer: _____
Occupation: _____
Work Phone #: _____
Length of Employment: _____
Monthly Salary: Gross $_____
Net $_____

SPOUSE INFORMATION

Name: _____
Social Security #: _____
Home Phone #: _____

Employer: _____
Occupation: _____
Work Phone #: _____
Length of Employment: _____
Monthly Salary: Gross $_____
Net $_____

OTHER ASSETS / INCOME

$_____ Interest/Dividends
$_____ Business
$_____ Alimony
$_____ Child Support
$_____ Social Security
$_____ State of NE/IA
$_____ Other Income

$_____ Checking Account
$_____ Savings Account
$_____ Autos
Year____ Make_____
Year____ Make_____
$_____ Home
$_____ Life Insurance

LIABILITIES

Home: ❒ Rent ❒ Buying Monthly Payment $_____

Bank Loans: *(please list)*	Original Balance	Unpaid Balance	Monthly Payment
_____	$_____	$_____	$_____
_____	$_____	$_____	$_____
_____	$_____	$_____	$_____
Finance Companies/Credit Union Loans			
_____	$_____	$_____	$_____
_____	$_____	$_____	$_____
_____	$_____	$_____	$_____

LIABILITIES cont'd

Credit Cards

_____	$_____	$_____	$_____
_____	$_____	$_____	$_____
_____	$_____	$_____	$_____

Other Liabilities	Original Balance	Unpaid Balance	Monthly Payment
_____	$_____	$_____	$_____
_____	$_____	$_____	$_____
_____	$_____	$_____	$_____

MONTHLY EXPENSES

Please provide copies of statements for phone, utilities, health insurance, car payments and credit card bills

$_____	Food	$_____	Natural Gas/Propane
$_____	Car Expense	$_____	Cable Television
$_____	Car Insurance	$_____	Water/Garbage
$_____	Health Insurance	$_____	Child Care
$_____	Life Insurance		Other *(please list)*
$_____	Home Telephone	$_____	_____
$_____	Cellular Telephone	$_____	_____
$_____	Electricity	$_____	_____

SIGNATURE

I hereby acknowledge that the information given to Midwest Eye Care, P.C. is true and correct to the best of my knowledge. I hereby authorize Midwest Eye Care, P.C. to verify any or all information given and I also authorize that a consumer credit report may be obtained if necessary.

_____ _____

Responsible Party Signature *Spouse Signature*

_____ _____

Date *Date*

Comments by Applicants:

_____

_____

FOR USE BY THE FINANCE DEPT ONLY

Reviewed By: _____ Date: _____

Summary:

_____

_____

Thank you for your cooperation and assistance.

Patient Health History Form

Please complete the following health history form. It will aid the doctor in providing you the best care as it relates to your vision problems.

Name:_____ Date:_____

1. Main vision problem: _____

   _____

2. Any present illness (such as cold, bronchitis, infection, etc.) in last two months?

   _____

   _____

3. Are you now or have you ever been treated for the following? If yes, gives dates:

   Heart trouble _____ Arthritis _____

   Lung trouble _____ Liver disease _____

   Tuberculosis _____ Bone/joint issues _____

   Diabetes _____ Retinal detachment _____

   Glaucoma _____ Kidney issues _____

   High blood pressure _____ Tendency to bleed _____

   If you have any of the issues listed above, please explain:

   _____
   _____
   _____
   _____

4. Previous surgeries (including eye surgeries and eye laser treatments) with dates:

   _____
   _____
   _____

5. Do you have any allergies to: _____ Aspirin _____ Latex
   _____ Iodine _____ Local anesthetic

6. Please list all of the prescription and over-the-counter medicines that you are taking:

_____

_____

7. Do you have any of the following:

_____	Sinus trouble	_____	Chest pain	_____	History of heart attack
_____	Asthma	_____	Dentures	_____	Shortness of breath
_____	Cough	_____	Stomach pain	_____	Get up at night to urinate
_____	Constipation	_____	Blood in stool	_____	Problems with your blood
_____	Hearing	_____	Emphysema	_____	Pain while urinating
_____	Back problems	_____	Sleep with two or more pillows		

If YES, explain: _____
_____
_____

8. Family History – List any glaucoma, retinal detachment, diabetes or high blood pressure. If deceased, also include age and cause of death.

Father _____

Mother _____

Brothers/sisters _____
_____

9. Please answer the following questions:

Can you see well enough to drive a car?	_____ Yes	_____ No
Can you see well enough to drive at night?	_____ Yes	_____ No
Can you see well enough to read?	_____ Yes	_____ No
Can you see well enough for outdoor activities?	_____ Yes	_____ No
Can you see well enough to recognize people?	_____ Yes	_____ No
Can you see well enough to perform hobbies?	_____ Yes	_____ No
Can you see well enough to hold a job?	_____ Yes	_____ No

10. Family physician – Name _____

Address _____

Phone _____

11. Your signature _____ Date _____

Form 6

Application Checklist

Please verify that you have are sending all of the following information to Midwest Eye Care as part of your application:

1. Form 1, Mission Cataract Initial Questions
2. Form 2, Mission Cataract Patient Responsibilities
3. Form 3, Authorization and Release of Information
4. Form 4, Financial Worksheet
5. Form 5, Patient Health History
6. Form 6, Application Checklist
7. 2021 W-2 form for applicant (and spouse if applicable)
8. Last 2 pay stubs for applicant (and spouse if applicable)
9. Copy of photo ID
10. Copy of insurance card
11. Copy of Medicaid denial or application
12. Copies of statements for recurring monthly expenses for cell and landline phones, utilities, health insurance, car payments and credit card bills.
13. Copy of Power of Attorney form, if someone is applying on behalf of a patient

Please do not submit this information until it is complete. Complete paperwork should be mailed to the following:

Call Center – Mission Cataract
Midwest Eye Care, PC
13500 California Street
Omaha, NE 68154

If you have any questions, please contact us at 402/552-2020.