<u>Easter Seals Hearing Aid Assistance Application Checklist</u>

Please review this checklist and begin gathering the required documents.

This will help you complete the application. Once you have attached the required documents, please check-off the item, and return this sheet with the application.

<u>Please be aware that without complete proof of income we cannot offer financial assistance.</u>

______ **A copy of applicant's (your) insurance card(s).**
Or other proof of medical insurance and what type of insurance it is. ***If you do not have insurance, you will need a signed and notarized letter to this effect.***

______ **A copy of your most recent hearing test** (if available).

______ **Applicant's last nine months of bank statements.**
We reserve the right to request and require these documents to verify your true financial need. ***If bank statements are not available, you must write a letter describing why, sign it and have it notarized.*** You may then provide other proof of monthly income such as a ***notarized*** letter stating how much you get from Social Security, or an employer, accompanied by the official document (i.e. your Social Security statement, paycheck stub, retirement statement, etc).

______ **Proof of income for all persons listed in this application as included in your household, unless this person is a dependant.**
Pay stubs, bank statements showing direct deposits, or signed and notarized letters from appropriate entities (i.e. Social Security, employers) showing benefits received. ***If you are not able to provide proof of income, you will need a signed and notarized letter to this effect.***

______ **Any out-of-pocket medical expenses (excluding co-pays and premiums) you have had in the last 12 months.**
This includes receipts for medications, vision, dental, etc.
We will deduct these from your household income to better represent what you live off of, and then assign you a percent reduction for hearing aid products and services, based on a sliding scale. ***Bills not yet paid will not be considered.***

______ **A signed, dated, and notarized application.**
There is a release page at the end of the application. Most banking and/or check-cashing institutions provide notary services.

Easter Seals Southern Colorado
225 S. Academy Blvd, Suite 104
Colorado Springs, CO 80910-2768
Voice (719) 574-9002 Fax (719) 574-1330

APPLICATION FOR HEARING AID ASSISTANCE

PLEASE READ THROUGH AND COMPLETE ALL PAGES (BOTH SIDES)

Date Application Completed: ____________

How did you hear about our program? Referred by (Name of Person or Organization):

____

Your (Applicant's) Name: ____

SSN: ___________-_____-__________ **D.O.B.:** _______________ **Age:** ____________

Sex: Male ☐ **Female** ☐

Address:____

City:___________________________________ **State:**________ **Zip Code:**______________

Primary Phone#: (____)__________________ **Other Phone#: (____)**________________

Employer: _____________________________ **Work Phone#: (____)**________________

Emergency Contact: ____________________ **Their Phone#: (____)**________________

Relationship:___________________________ **(Daughter, Brother, Friend, etc.)**

Hearing and Health Questions:

Please answer the following questions to the best of your ability:

1. Do you have medical insurance? **Yes** ☐ **No** ☐

- ***If you answered yes, attach a copy of your card(s) to this application.***

2. Do you have a co-pay for each office visit? **Yes** ☐ **No** ☐

3. Are you currently wearing hearing aids? **Yes** ☐ **No** ☐

- ***If you answered yes, please bring them to your first appointment.***

4. When and where did you purchase your hearing aids? ______________________________

____

5. What kind are they? Do you know the manufacturer? ______________________________

____

6. Do you think your hearing aid(s) need repair? **Yes** ☐ **No** ☐

7. Do you have a Primary Care Physician? **Yes** ☐ **No** ☐

Name of Primary Care Physician____

Phone #: ______________________________

8. When did you last see an Ear, Nose and Throat Doctor?

Date:______________ **Name of ENT:** ______________________________________

Phone #: ______________________________

9. When did you last see an audiologist?

Date: ______________ **Name of audiologist:** ______________________________

Phone #: ______________________________

10. Did you have a hearing test? **Yes** ☐ **No** ☐

- ***If you answered yes, please attach a copy of it to this application.***

11. Are you currently, or have you experienced any of the following:

Periodic or chronic ear infections	**Yes** ☐	**No** ☐
Wax build-up	**Yes** ☐	**No** ☐
Periodic or chronic earaches	**Yes** ☐	**No** ☐
Tinnitus, sounds or ringing in your ears	**Yes** ☐	**No** ☐
Ear drainage	**Yes** ☐	**No** ☐

Demographic Questions:

We are required by Easter Seals National to collect certain information on those clients that are served by the programs provided by Easter Seals Southern Colorado. This information will be held strictly confidential in accordance with HIPAA requirements and will only be used for statistical analysis.

Please respond to these three questions:

1. Do you live within the city limits of Colorado Springs? Yes ☐ No ☐

2. What is your Race?

__ African American __ Asian __ Caucasian __ Hispanic __ Native American __ Other

3. Do you have a disability? If so please specify what kind:

☐ **Congenital Anomalies (i.e. spina bifida, cleft palate, down syndrome, etc.)**

Please specify:____

☐ **Neurological disorders (i.e. multiple sclerosis, cerebral palsy, epilepsy, deaf/hearing impaired, blind/visually impaired, etc.)**

Please specify:____

☐ **Mental disability (i.e. autism, attention deficit disorder, mental retardation, developmental delays, etc.)**

Please specify:____

☐ **Other (i.e. post-polio, stroke survivor, etc.)**

Please specify:____

HOUSEHOLD FINANCIAL INFORMATION

YOU MUST PROVIDE COMPLETE PROOF OF INCOME
OR THIS APPLICATION CAN NOT BE PROCESSED

We reserve the right to require **nine months** of bank statements to verify true financial need. If bank statements are not available, *you must* write a letter describing why, sign it and have it notarized. *You may then* provide other proof of monthly income such as a letter from Social Security, or from an employer, stating the amount of income**.**

Family Size __________(People living in the household)

Applicant's Monthly Income $_________________ **Source: ________________ (i.e. employment, Social Security, SSI, pension, retirement, etc)**

Applicant's Additional Monthly Income $_________________ **Source: ________________ (i.e. employment, Social Security, SSI, pension, retirement, etc)**

Other Family Members' Monthly Income $_________________ **Source:________________ (i.e. employment, Social Security, SSI, pension, retirement, etc**

TOTAL HOUSEHOLD INCOME $ ________________

Yearly Medical Expenses $ ________________
(Excluding co-pays and Insurance premiums)

***Attach copies of receipts for the past 12 months: Prescriptions, dental expenses, vision expenses, etc.**

For EASTER SEALS SOUTHERN COLORADO Use Only

Total Yearly Income (income less medical expenses):	______________________
Percent Discount Assigned:	______________________
Easter Seals Staff Approval:	______________________

RELEASE

I certify that the information I have provided is true and accurate to the best of my knowledge. Further, information regarding my medical insurance (Medicaid, Medicare, or private insurance) will be available, as needed, for billing. Easter Seals Southern Colorado (ESSC) will inform me, prior to charges being incurred, of my discount.

I understand that this application is made so that ESSC's program can determine my eligibility for the uncompensated services (under the Hill-Burton Act) based on the established criteria on file with ESSC. If any information I have provided is found to be fraudulent, I understand that the ESSC may re-evaluate my financial status and take whatever action is deemed necessary.

I authorize ESSC to collect and release information related to my hearing loss from any past or current provider. I hereby release ESSC from any liability in furnishing needed information.

I have made application for funding and/or services through Easter Seals Southern Colorado.

All services will be performed by professional vendors and providers. I agree to hold harmless all those associated with the ESSC from any claims arising through the services and/or equipment provided by this program.

_______________________________________ ____________________

Applicant's Signature (or parent/guardian) **Date**

This application for ________________________________ has been subscribed

and affirmed, or sworn to before me in the county of ____________________________

State of Colorado, this ______________ day of _________ 20__________.

____________________________________ ______________________

Notary Signature **Commission Expiration Date**

(Official seal)