



Dear Patient,

Thank you for contacting Hearing the Call - Colorado for hearing healthcare assistance. We are so glad that you have learned about our program, and we are excited to begin serving you for all of your future hearing healthcare needs.

Hearing the Call - Colorado is a 501c3 nonprofit organization established to meet the hearing needs of low-income Coloradans. We provide hearing services for a reduced fee that will be determined on a sliding scale system based on household size and income. Our goal is to help make hearing care more affordable and accessible to our patients. This assistance comes through donations from audiologists as well as donors across Colorado and the United States. We ask all participants to pay this generosity forward through the commitment of volunteer hours at their charity of choice.

To qualify for our program, you must meet certain financial criteria based on Federal Poverty Guidelines. Please take a few moments to review this packet which includes application documentation requirements. Enclosed is a copy of our patient intake form, HIPAA disclosure, Eligibility and Consent Form, and required documents list.

Please fill out the Intake Form (both sides), HIPAA disclosure, Eligibility and Consent Form, and submit a copy of the required documentation within the next 90 days. Your privacy is of utmost importance to us and these documents are only viewed for eligibility determination. Once the documents have been reviewed and accepted by our board you will receive notification that you will be able to begin your hearing healthcare journey. If you have any questions about this process or about the required paperwork, please do not hesitate to call us. We would also be happy to do a pre-screening over the phone to determine whether or not you meet the income criteria before returning the paperwork. You can reach us by leaving a message on our direct line at: 720-593-0898. You can also reach us by email us at [colorado@hearingthecall.org](mailto:colorado@hearingthecall.org)

Sincerely,

Chandace Jeep, Au.D.  
Julie Eschenbrenner, Au.D.

D'Anne Rudden, Au.D.  
Julie Raney, M.S. CCC-A

Dusty Jessen, Au.D.  
Rachel McArthur, Au.D.

Hearing the Call - Colorado  
[colorado@hearingthecall.org](mailto:colorado@hearingthecall.org)



## Demographic Information

Thank you for taking the time to complete the following survey. The information collected will be confidential (see our HIPAA disclosure). The information obtained below will not be used in determining eligibility for our services, but may be used strictly in the collection of general data and/or reporting for the nature of and scope of our work as a nonprofit organization. This information helps us in identifying disparities in our community and to help in making informed quality improvement efforts. Because our organization is nonprofit, we rely on public funding sources so that we may continue to provide services and hearing healthcare to the underinsured, low-income, and uninsured residents of our community. By completing our survey, you help us in determining the need and in helping us to better provide these services to you and others in our community. Thank you for your time. Please circle the appropriate responses below:

**Do you have any physical and/or diagnosed mental disability?** Yes or No

If yes, please briefly describe: \_\_\_\_\_

**What is your gender identity?** Male Female

**What is your age?** 18-24 25-34 35 – 44 45 – 55 56 – 65 66 – 79 Over 80

**What is your highest level of education completed?**

Less than High School Diploma/GED Some College 2-Yr Degree 4-Yr Degree Master's Degree Doctorate

**Annual Household Income** (circle) less than \$10,000 \$10,000 to \$18,000 \$19,000-\$25,000 over \$26,000 \_\_\_\_\_

**What is your Primary language:** English Spanish ASL Burmese Other: \_\_\_\_\_

**What is your Secondary Language (if any):** English Spanish ASL Burmese Other: \_\_\_\_\_

**Do you utilize an interpreter for your medical/wellness visits?** Yes No Sometimes

**If you answered yes or sometimes, what type of interpreter?** ASL or Spoken Language: \_\_\_\_\_

**How do you get to your medical/wellness visits?** Car Friend Public Transportation Other: \_\_\_\_\_

**What is your primary racial identity? (Circle all that apply)**

African African-American Burmese/Karin Asian Caucasian Hispanic

Middle Eastern Native American

Other Race Not Listed: \_\_\_\_\_ Not Specified

I choose to provide only partial information above.

I choose not to provide any information above.

**INITIAL** \_\_\_\_\_



## Eligibility & Consent Form

### **To be completed by applicant:**

Hearing the Call Colorado is available to children and adults in Colorado who have been diagnosed with a hearing loss.

The following eligibility requirements must be met to enroll in this project:

- Diagnosed with hearing loss in one or both ears
- Income not to exceed 250% above the poverty line
- Live within the state of Colorado
- Ability to complete a total of 10 hours of community service

### **By signing this form, I certify that:**

- 1) I meet all of the HTC-CO eligibility requirements listed above.
- 2) All of the financial information I submitted for program eligibility was truthful and accurate to the best of my knowledge.
- 3) I am not withholding any requested financial information that was requested as part of the program application.
- 4) I give consent to enroll and receive services through Hearing the Call Colorado, in collaboration with Hearing the Call, a 501 (c) (3) organization.
- 5) I give consent to allow Hearing the Call Colorado to view my personal financial information for the purpose of determining if I meet the HTC-CO financial eligibility requirements.

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Patient/ Guardian Name

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Date

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Patient/Guardian Signature



## Eligibility Document Checklist

Please make copies of the following items that are applicable to you and your household, and return them to our office within 90 days. Please include documents for all adults over age 18 living in the household. Include only proof of social security/disability income if a child is under age 18.

**Applicant Name:** \_\_\_\_\_

**DOB:** \_\_\_\_\_

ITEM	NOTES	
Intake Form (Both Sides)	Yes	No
Copy of Driver's License or State ID	Yes	No
Medicaid ID/Insurance information	Yes	Not Applicable
Most Recent Paystubs (need at least 2)	Yes	Not Applicable
Proof of Income from Child Support/Spousal Support	Yes	Not Applicable
Most Recent Income Tax Return (last two years)	Yes	Not Applicable
Bank Statement (from the last 60 days)	Yes	Not Applicable
IRA/Investment Income/401K/Stocks/Bonds or other assets	Yes	Not Applicable
Proof of Residence (utility bill, lease, or other)	Yes	Not Applicable

Proof of Social Security or Disability Income      Yes      Not Applicable

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Proof of Unemployment Income      Yes      Not Applicable

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Proof of TANF, Financial Assistance Income, or Food Stamps      Yes      Not Applicable

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Proof of Extenuating Circumstance and/or Hardships (such as payments on medical bills)      Yes      Not Applicable

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***\*To qualify for the program your household income must not exceed 250% above 2020 Federal Poverty Guidelines***

<b>Household of 1:</b>	\$31,900.00	<b>Household of 5:</b>	\$76,700.00
<b>Household of 2:</b>	\$43,100.00	<b>Household of 6:</b>	\$87,900.00
<b>Household of 3:</b>	\$54,300.00	<b>Household of 7:</b>	\$99,100.00
<b>Household of 4:</b>	\$65,500.00	<b>Household of 8:</b>	\$110,300.00

*\*You may have no more than \$10,000 in cash reserves and/or savings*

*\*You may have no more than \$50,000 in accessible finances in retirement and/or investments*

*\*Proof of household income and assets is required. "Household" is defined as any individuals who live together in the same residence (regardless of familial relationship) who purchase, share, and/or prepare food together. If an adult over 18 is living in the home and paying rent/sharing expenses (must be documented), he/she can be classified as a boarder and their portion of rent only will be attributed as income to the household.*

If you have any questions, please contact us by email at [colorado@hearingthecall.org](mailto:colorado@hearingthecall.org)

\*Application materials are viewed by Hearing the Call Colorado Application Board Members only.

\*When eligibility is determined, all financial and application paperwork is shredded.

\*Names and addresses of applicants are never sold or shared with others.

\*A credit report may be requested.



# HIPAA-Authorization to Use and Disclosure of Health Information

Patient Name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

I request and authorize Hearing the Call - Colorado to disclose my protected health information as described below. I understand that if the person/organization authorized to receive and use the information is not a health plan or health care provider, such as hearing aid manufacturers, ear mold companies or buying groups the disclosed information may no longer be protected by federal privacy regulations. I consent to Hearing the Call - Colorado releasing protected health as detailed below.

My protected health information may be used or disclosed to the following:

- 1. Send appointment reminders to your home/email? Yes  No
- 2. Leave the following information on your home, cell or work voicemail?
  - Appointment Information Yes  No
  - Billing Information Yes  No
  - Medical Information Yes  No

I give my permission to share the following information with the person(s) listed below:

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Appointment: Yes  No  Billing: Yes  No  Medical: Yes  No

I acknowledge that I received a copy of Hearing the Call - Colorado’s Notice of Privacy Practices. I further acknowledge that a copy of the current notice will be posted in the reception area of each individual participating office, on the Hearing The Call – Colorado web page and that I will be offered a copy of any amended Notice of Privacy Practices at each appointment.

This Notice informs me how Hearing the Call - Colorado will use my health information for the purposes of my treatment and/or payment for my treatment. This Notice explains in more detail how Hearing the Call - Colorado. may use and share my health information for other than treatment, payment, and health care operations. Hearing the Call - Colorado will also use and share my health information as required/permitted by law.

I understand that I have the right to request restrictions as to how my protected health information may be used or disclosed by Hearing the Call - Colorado. I understand that this authorization is in effect until written notice of revocation is received. I may revoke this authorization at any time by providing written notice of revocation to Hearing the Call - Colorado, 195 S. Main St. Suite 8, Longmont, CO 80501. I understand that revocation of this authorization will not affect any action the above named entity took in reliance on this authorization before the above named entity received my written notice of revocation.

I authorize Hearing the Call – Colorado’s use and disclosure of my protected health information as described above. I understand that this authorization is voluntary and that Hearing the Call - Colorado cannot condition my treatment, services, etc. on the signing of this authorization. I understand that if I am signing on behalf of a minor child, this authorization will expire upon the child reaching the age of 18, unless there is proof of legal guardianship.

\_\_\_\_\_  
Printed name of patient or personal representative

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of patient or personal representative

\_\_\_\_\_  
Date

For assistance completing the authorization form contact [info@longmonthearing.com](mailto:info@longmonthearing.com)