

Dear Patient,

Thank you for contacting Hearing the Call-Westchester 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-Westchester is a 501c3 nonprofit organization established to meet the hearing needs of low-income Westchester residents. We provide hearing services for a reduced fee that are 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 from Westchester County, New York and across 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 & consent form, and a required documents list.

Please fill out the intake form (both sides), HIPAA disclosure, eligibility & 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 and 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: (914) 893-8066. You can also reach us by email us at HTCWestchester@audiology-speech.com.

Sincerely,

Dr. Nancy Datino Au.D.



Connecting People to People and People to Community

Patient Name: _____ D.O.B. ____/____/____
(First, Last, M.I, MM/DD/YYYY)

Mailing Address (Street):

City, State, Zip _____

Home Phone # _____

Cell Phone # _____

Work Phone # _____ SSN: _____ Sex: M F

E-Mail: _____ Occupation: _____

Household Size (please circle) 1 2 3 4 5 6 7 8 9+ _____

Marital Status: ____ Married ____ Single ____ Divorced ____ Widowed ____ Domestic Partnership

How would you rate your hearing on a scale 1-10 with 1 being the worst and 10 being the best?

Please circle:
1 2 3 4 5 6 7 8 9 10

Emergency Contact: _____ Phone #: _____

Relationship to Patient: _____

Primary Care Physician: _____ Phone #: _____

Referred By: _____ Insurance Type: None Medicaid Other _____

Non-Discrimination Policy: It is the commitment and policy of all participating Entheos Audiology Cooperative Westchester offices and Hearing the Call Westchester that we do not discriminate against any person on the basis of race, age, sex, religion, gender identity or expression, sexual orientation, national origin, and/or physical or mental disability in the admission to, participation in, or receipt of services and benefits of any of its programs and activities, or for employment.

******* PLEASE READ CAREFULLY AND SIGN BELOW *******

___ I give permission to my Audiology and Hearing Center to release information, verbal and written, contained in my medical record and other related information, to my insurance company, rehab nurse, case manager, attorney, employer, related healthcare providers, assignees and/or beneficiaries and all other related persons. Information without patient identifiers may be used for quality purposes, research, or reports to funders.

___ I acknowledge that I have received and reviewed the Health Insurance Portability & Accountability Act (HIPAA) policy of this office.

___ I understand and agree that I am ultimately responsible for the balance of my account for professional services or purchases rendered. I understand that I may request documentation to submit to my insurance or health plan on my own and that Hearing the Call- Colorado will not submit this for me.

___ I have read all the information on this sheet and have completed the above answers, certify this information is true and correct to the best of my knowledge and hereby give my Audiology and Hearing Center permission to treat my concerns.

___ The FDA has determined that it is in my best health interest to have a medical evaluation by a licensed physician (preferably a physician who specializes in diseases of the ear) before purchasing hearing instruments, I have been advised by my Audiologist and Hearing Center and/or its agents about this determination and hereby waive this requirement.

I have read and understand all the above information.

Signature : _____ Date: _____

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 check the appropriate responses below:

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

If yes, please briefly describe: _____

What is your gender identity? M F Non-binary Prefer not to respond

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

Bachelors/4-Yr Degree

Graduate/Professional Degree

Annual Household Income: less than \$10,000 \$10,000 to \$18,000 \$19,000-\$25,000 over \$26,000

What is your Primary language? (ie. English, Spanish, Burmese, etc) _____

What is your Secondary Language (if any)? _____

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

If you answered yes or sometimes, what type of interpreter? ASL Spoken Language

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

What is your primary racial identity? (Check all that apply) African-American Asian Caucasian Hispanic

Middle Eastern Burmese/Karin Native American Other (not listed) _____ Choose not to disclose

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- Westchester is available to children and adults in Westchester 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 county of Westchester
- 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-WESTCHESTER 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- Westchester, in collaboration with Hearing the Call, a 501 (c) (3) organization.
- 5) I give consent to allow Hearing the Call Westchester to view my personal financial information for the purpose of determining if I meet the HTC-WESTCHESTER financial eligibility requirements.

Patient/Guardian Name

Date

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 <input type="checkbox"/>	NO <input type="checkbox"/>
Copy of Driver's License or State ID	YES <input type="checkbox"/>	NO <input type="checkbox"/>
Medicaid ID/Insurance Information	YES <input type="checkbox"/>	N/A <input type="checkbox"/>
Most Recent Paystubs (at least 2)	YES <input type="checkbox"/>	N/A <input type="checkbox"/>
Support- Proof of Income from Child/Spousal Support	YES <input type="checkbox"/>	N/A <input type="checkbox"/>
Most Recent Income Tax Returns (last 2 years)	YES <input type="checkbox"/>	N/A <input type="checkbox"/>
Bank Statement (last 60 days)	YES <input type="checkbox"/>	N/A <input type="checkbox"/>
Other Assets/IRA/Investment Income/401K/Stocks/Bonds	YES <input type="checkbox"/>	N/A <input type="checkbox"/>
Proof of Residence (utility bill, lease or other)	YES <input type="checkbox"/>	N/A <input type="checkbox"/>
Proof of Social Security Disability Income	YES <input type="checkbox"/>	N/A <input type="checkbox"/>
Proof of Unemployment Income	YES <input type="checkbox"/>	N/A <input type="checkbox"/>
Proof of Food Stamps/TANF/other financial assistance income	YES <input type="checkbox"/>	N/A <input type="checkbox"/>
Hardship (ie. medical bill payments) or proof of extenuating circumstance	YES <input type="checkbox"/>	N/A <input type="checkbox"/>

****To qualify for the program, your household income must not exceed 250% above 2021 Federal Poverty Guidelines****

Household of 1: \$31,900.00 **Household of 5:** \$76,700.00

Household of 2: \$43,100.00 **Household of 6:** \$87,900.00

Household of 3: \$54,300.00 **Household of 7:** \$99,100.00

Household of 4: \$65,500.00 **Household of 8:** \$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 HTCWestchester@audiology-speech.com or by phone at (914) 893-8066.

**Application materials are viewed by Hearing the Call Westchester 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- Westchester 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- Westchester 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 - Westchester 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 – Westchester 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 - Westchester 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 - Westchester may use and share my health information for other than treatment, payment, and health care operations. Hearing the Call - Westchester 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 - Westchester. 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- Westchester, 350 Theodore Fremd Avenue, Suite 220, Rye, NY 10580. 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- Westchester use and disclosure of my protected health information as described above. I understand that this authorization is voluntary and that Hearing the Call- Westchester 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 HTCWestchester@audiology-speech.com.