Thank you for your interest in
Hearing the Call-Delaware Valley

Please complete the paperwork and return it for review by the Qualification Committee.

Drop Off: 905 W. Sproul Road Suite 201, Springfield PA 19064

Mail: 130 S. State Road Suite 201, Springfield PA 19064

E-Mail: info@pacenterforhearing.com

Fax: 484-470-6001

Thank you, we look forward to serving your hearing needs.

HEARING the CALL
DELAWARE VALLEY
GIVING
A Hand Up For Hearing Care

Dear Patient,

Thank you for contacting Hearing the Call - Delaware Valley (HTC-DV) 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.

PA Center for Hearing and Balance has partnered with Hearing the Call - Delaware Valley. A 501c3 nonprofit organization established to meet the hearing needs of low-income Pennsylvanians. 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 Pennsylvania 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, HIPAA disclosure, Eligibility and Consent Form, and submit a copy of the required documentation. 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. You can reach us by leaving a message on our direct line at: 610-438-5203. You can also reach us by email at info@pacenterforhearing.com

Sincerely,

Liliana Cabrera Piccinini, AuD
and PA Center for Hearing and Balance Team

Hearing the Call - Delaware Valley
info@pacenterforhearing.com

HEARING the CALL
DELAWARE VALLEY
GIVING
A Hand Up For Hearing Care

Patient Name: _____ D.O.B. ___/___/_____
First Last MI M D Y

Mailing Address: _____

Home Phone # _____ Cell Phone

Work Phone # _____ SSN: _____ Sex: ☐ M ☐ F

E-Mail Occupation:

How many people live in your Household ? Marital Status:

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

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 Entheos Audiology Cooperative and Hearing the Call- Delaware Valley 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 PA Center for Hearing and Balance and HTC - DV to release information, verbal and written, contained in my 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.

☐ I understand that I may request documentation to submit to my insurance or health plan on my own and that HTC -DV 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 PA Center for Hearing and Balance and HTC- DV 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, PA Center for Hearing and Balance, HTC-DV 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 circle 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? ☐ Male ☐ Female

What is your age? ☐ Below 18 ☐ 18-24 ☐ 25-34 ☐ 35-44 ☐ 45-54 ☐ 55-65 ☐ 66-79 ☐ 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 ☐ Diploma/GED

Annual Household Income ☐ less than $10K ☐ $10 to $18K ☐ $19K to $25K ☐ over $26K

What is your primary language ☐ English ☐ Spanish ☐ ASL ☐ 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 Spoken Language:

How do you get to your appointments? ☐ Car ☐ Friend ☐ Public Transportation Other: _____

What is your primary racial identity? (Choose all that apply):

☐ Black or African- American ☐ Asian ☐ American Indian or Alaskan Native

☐ Hispanic or Latino ☐ Native Hawaiian or Other Pacific Islander ☐ White

Other Race Not Listed: _____

☐ 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 Delaware Valley is available to children and adults in Pennsylvania 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 Pennsylvania
- 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-DV 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) If NO financial documentation was submitted, I certify that NO such documentation exists.
4) I am not withholding any requested financial information that was requested as part of the program application.
5) I give consent to enroll and receive services through Hearing the Call Delaware Valley, in collaboration with Hearing the Call, a 501 (c) (3) organization.
6) I give consent to allow Hearing the Call Delaware Valley to view my personal financial information for the purpose of determining if I meet the HTC-DV 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. 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
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
Proof of Unemployment Income	☐ Yes	☐ Not Applicable
Proof of Financial Assistance Income, or Food Stamps	☐ Yes	☐ Not Applicable
Proof of Extenuating Circumstance and/or Hardships (list below)	☐ Yes	☐ Not Applicable

_____

To qualify for the program your household income must not exceed 250% above 2020 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 info@pacenterforhearing.com

*Application materials are viewed by Hearing the Call Delaware Valley 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 - Delaware Valley 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 - Delaware Valley 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 - Delaware Valley'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 – Delaware Valley 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 - Delaware Valley 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 - Delaware Valley. may use and share my health information for other than treatment, payment, and health care operations. Hearing the Call - Delaware Valley 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 - Delaware Valley. 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 - Delaware Valley, 130 S. State Rd. Suite 201, Springfield PA 19064. 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 – Delaware Valley's use and disclosure of my protected health information as described above. I understand that this authorization is voluntary and that Hearing the Call - Delaware Valley 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@pacenterforhearing.com

PA Center for Hearing and Balance and Hearing the Call - Delaware Valley
905 W. Sproul Road Suite 201, Springfield PA 19064
P: (610) 438-5203 Fax :(484) 470-6001

VIDEO & PHOTOGRPHY CONSENT AND RELEASE FORM

I, _____ hereby give permission to PA Center for Hearing and Balance - Hearing the Call Delaware Valley (HTC-DV) to use and reproduce my image, likeness, voice, and name (collectively, "Image") and to authorize others to use my Image in any manner HTC-DV elects in any and all media now known or hereafter discovered or developed, in perpetuity, throughout the universe including but not limited to reproducing my Image in print publications, web sites, and audio visual broadcasts. I understand and agree that HTC-DV will own all rights in my Image, including all rights under copyright.

I expressly waive any right I might have of prior approval over how and where my Image is used and compensation and all rights of privacy and under any Federal or State statutes that may apply. I forever release and discharge HTC-DV, and their respective officers, employees, agents and other persons acting within the scope of their authority from any and all claims or causes of action, now known or later discovered, relating to or arising out of use of my Image, including but not limited to claims for invasion of privacy or misappropriation, right of publicity and defamation arising out of the use and exploitation of my Image.

I represent that I am over the age of 18 years, that I have read this permission, am fully familiar with its contents and meaning, and have been given the opportunity to consult counsel of my choosing prior to signing this Permission and Release.

_____ _____
Printed name of patient or personal representative Date

_____ _____
Signature of patient or personal representative Date