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**Hearing The Call-Hearing HOPE Project**

**Eligibility Requirements and Documentation**

Thank you for your interest in the Hearing the Call Hearing Hope Project. The Hearing HOPE Project is a local project organized by Auglaize and Sidney Audiology, in partnership with Entheos Hearing Connection, to provide quality audiology care to the underserved and uninsured in West Central Ohio. To qualify for financial services through this program you must provide proof of household income, fall within our program guidelines for financial assistance, and commit to small personal investment through volunteer service hours as a partial payment for hearing aids and services. Please make a copy of the following items that are applicable to you and your household and return to our office.

**Submit documentation to: HTC- Hearing HOPE Project 208 Defiance St. Wapakoneta, OH 45895 419-739-7575 or email to auglaizeaudiology@bright.net.**

* Your picture ID (driver's license or state ID)
* Proof of residency (ex: bring a utility bill or lease with your current address)
* If Applicable Your CURRENT pair of hearing aids (working or non-working)
* Proof of income that applies to your household- **include all the statements listed below that apply.** For minors the information required is that of ALL the working adults in the home, as well as benefit letters if the minor receives disability.

 ***NOTE:*** Failure to bring all financial documents will result in rescheduling your appointment and delaying entrance into our program.

**Required statements/information you MUST bring to your appointment:**

* 2 of your most recent paystubs
* Your most recent income tax return
* 2 of your most recent bank statements (the last two FULL months)
* Documentation of ALL of your IRA/Investments Incomes/401K/Stocks/Bonds or other assets
* Proof of Social Security or disability income
* Proof of government financial assistance
* Proof of residence (utility bill, lease, or other)
* Copy of Driver's license or State ID and Medicaid ID

Please call if you have any question about these documents **BEFORE** your appointment

***To qualify for the program your household income must not exceed 250% above 2018 Federal Poverty Guidelines***

**Household of 1:** $30,350.00 **Household of 5:** $73,550.00

**Household of 2:** $41,150.00 **Household of 6:** $84,350.00

**Household of 3:** $51,950.00 **Household of 7:** $95,150.00

**Household of 4:** $62,750.00 **Household of 8:** $105,950.00

***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.***



**Eligibility & Consent Form**

**To be completed by applicant:**

Hearing the Call- Hearing HOPE Project is available to adults in and around Auglaize, Allen, Shelby, and Mercer counties 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 Ohio
* Ability to complete a total of 10 hours of community service, service at your place of worship, or 10 random acts of kindness
* Willing to pay $75 per hearing aid (Payment options avaialalbe)

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

1. I meet all the 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-Hearing HOPE Project, in collaboration with Hearing the Call, a 501 (c) (3) organization.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Patient/ Guardian Name (printed)

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Patient/Guardian Signature Date

**To be completed by Audiologist:**

Hearing loss type & degree: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Hearing exam has been completed within the last 6 months: Yes No

Health insurance information has been reviewed and patient does have a hearing aid benefit through his/her PRIVATE health insurance: Yes No

Financials have been reviewed and patient qualifies for the program:     Yes    No

**I give my consent for the above applicant to participate in Hearing the Call-Hearing HOPE Project:**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Audiologist Name

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Audiologist Signature Date



**-HIPAA-**

Authorization for the Use or Disclosure of Protected Health Information (PHI)

For the purposes of diagnosing or providing hearing care and treatment for me, I consent to the use or disclosure of my Protected Health Information (including Audiograms) to the following (hereinafter, Providers):

* Auglaize Audiology
* Sidney Audiology, a division of Auglaize Audiology

I understand that diagnosis or treatment for me by the Providers may be conditioned upon my consent as evidenced by my signature on this document.

I understand I have the right to request a restriction as to how my PHI is used or disclosed to carry out hearing care and treatment. Providers are not required to agree to the restrictions that I may request. However, if Providers agree to a restriction that I request in writing, the restriction is binding to Providers. I have the right to revoke this consent, in writing, at any time, except to the extent that Providers have taken action in reliance on this consent.

My Protected Health Information (PHI) means health information, including my demographic information, collected from me and created or received by my physician, another healthcare provider, a health plan, my employer or a healthcare clearinghouse. This PHI relates to my past, present or future physical or mental health or condition and identifies me, or there is reasonable basis to believe the information may identify me.

I consent to Providers’ use or disclosure of my PHI for purposes of delivering relevant product and/or technology marketing communication to me. I acknowledge that Providers may receive financial remuneration from the manufacturer in connection with such communication.

I acknowledge that I have been given the opportunity to review Providers’ Notice of Privacy Practices and that a copy is available both for review and my own records should I so inquire.  I understand that should I refuse to sign this acknowledgment of receipt, Providers are not obliged to treat me.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_

Signature of Patient or Personal Representative Date

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Print Name of Patient or Personal Representative

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Description of Personal Representative’s Authority



**Intake Form**

Patient Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ D.O.B. \_\_\_/\_\_\_/\_\_\_\_\_

 First Last MI M D Y

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?

Circle One: 1 2 3 4 5 6 7 8 9 10

Emergency Contact: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Relationship to Patient: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Primary Care Provider: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Located in:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Referred By: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Insurance Type: None Medicaid Other\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Non-Discrimination Policy:** It is the commitment and policy of Auglaize Audiology that it does 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 Auglaize and Sidney Audiology 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 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 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** \_\_\_\_less $10,000 \_\_\_\_$10,000-$18,000 \_\_\_\_$19,000-$25,000 \_\_\_\_$26,000+

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

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

**If English is not your primary language, do you utilize an interpreter for your medical/wellness visits?** Yes No Sometimes

**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 \_\_\_\_African-American \_\_\_\_Burmese/Karin \_\_\_\_Asian \_\_\_\_Caucasian \_\_\_\_Hispanic **\_\_\_\_**Middle Eastern \_\_\_\_Native American

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

**Please initial below whichever is true:**

\_\_\_\_\_\_I respectfully choose to provide only partial information above.

\_\_\_\_\_\_I respectfully choose not to provide any information above.

\_\_\_\_\_\_I choose to share my information above and do initial that it is true to the best of my knowledge.