



Dear Applicant,

Thank you for contacting Hearing the Call – Central Jersey 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 your future hearing healthcare needs.

Hearing the Call – Central Jersey is a partnership between Hearing the Call, a 501c3 nonprofit organization, and Oracle Hearing, established to meet the hearing needs of income eligible adults in the Central New Jersey area. The partnership allows for hearing services to be offered at a reduced fee based on the applicant's household size and income. Our goal is to make quality hearing care more affordable and accessible to those in need. This assistance comes through donations from audiologists and other donors across New Jersey and the United States. We ask all participants to pay this generosity forward through 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 documentation requirements for the application. Simply complete the following forms and return them, along with your supporting documents, to 134 Franklin Corner Road, STE 104, Lawrenceville, NJ 08648.

- Intake Form
- Demographic Information
- Eligibility Document Checklist
- Eligibility & Consent Form
- Video & Photography Consent Form

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 team you will receive notification and further instructions. 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 at 609-896-5870 or email at info@oraclehearingcenter.com.

Sincerely,

Oracle Hearing Center & Hearing the Call – Central Jersey

www.oraclehearingcenter.com
134 Franklin Corner Rd, Ste 104
Lawrenceville, NJ 08648



Applicant Name: _____ Date of Birth: _____
 First Last MI MM DD YYYY

Referred By: _____

Contact Information:

Mailing Address: _____

Home Phone: _____ Cell Phone: _____ Work Phone: _____

Email Address: _____

Personal Information:

SSN: _____ Gender Identity: M F Other

Occupation: _____ Employer: _____ N/A

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?

1 --- 2 --- 3 --- 4 --- 5 --- 6 --- 7 --- 8 --- 9 --- 10

Emergency Contact:

Name: _____ Relationship: _____ Phone #: _____

Primary Care Physician: _____ City: _____ Phone: _____

Insurance Type:

- None
- Medicaid
- Medicare
- Other

Non-Discrimination Policy: It is the commitment and policy of Oracle Hearing Center and Hearing the Call – Central Jersey, that we do not discriminate against any person based on 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.



Eligibility & Consent Form

Revised 3/25/2022

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

1. Diagnosed with hearing loss in one or both ears
2. Income not to exceed 250% above the federal poverty level
3. Must not have a private health insurance benefit that covers hearing aids
4. No more than \$10,000 in cash reserves and/or savings.
5. No more than \$50,000 in accessible finances in retirement and/or investments.
6. Ability to complete a total of 10 hours of community service

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. Depending on household size, the applicant's total household income must be under:

Household of 1:	\$33,975.00	Household of 5:	\$81,175.00
Household of 2:	\$45,775.00	Household of 6:	\$92,975.00
Household of 3:	\$57,575.00	Household of 7:	\$104,775.00
Household of 4:	\$69,375.00	Household of 8:	\$116,575.00

By signing this form, I certify that:

1. I meet all of 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 from Oracle Hearing Center and Hearing the Call – Central Jersey, in collaboration with Hearing the Call, a 501c3 organization.
5. I give consent to allow Oracle Hearing Center and all individuals associated with Hearing the Call – Central Jersey to view my personal financial information for the purpose of determining if I meet the financial eligibility requirements.

Applicant/Representative Name: _____

Applicant/Representative (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 Other

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: _____

I choose to provide only partial information above.

I choose not to provide any information above.

INITIAL _____

www.oraclehearingcenter.com
134 Franklin Corner Rd, Ste 104
Lawrenceville, NJ 08648



Eligibility Document Checklist

Applicant Name: _____ **DOB:** _____

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.

ITEM	NOTES
Copy of Driver's License or State ID	<input type="checkbox"/> Yes <input type="checkbox"/> No
Medicaid ID/Insurance information	<input type="checkbox"/> Yes <input type="checkbox"/> Not Applicable
Most Recent Paystubs (need at least 2)	<input type="checkbox"/> Yes <input type="checkbox"/> Not Applicable
Proof of Income from Child Support/Spousal Support	<input type="checkbox"/> Yes <input type="checkbox"/> Not Applicable
Most Recent Income Tax Return (last two years)	<input type="checkbox"/> Yes <input type="checkbox"/> Not Applicable
Bank Statement (from the last 60 days)	<input type="checkbox"/> Yes <input type="checkbox"/> Not Applicable
IRA/Investment Income/401K/Stocks/Bonds or other assets	<input type="checkbox"/> Yes <input type="checkbox"/> Not Applicable
Proof of Residence (utility bill, lease, or other)	<input type="checkbox"/> Yes <input type="checkbox"/> Not Applicable
Proof of Social Security or Disability Income	<input type="checkbox"/> Yes <input type="checkbox"/> Not Applicable
Proof of Unemployment Income	<input type="checkbox"/> Yes <input type="checkbox"/> Not Applicable
Proof of Financial Assistance Income, or Food Stamps	<input type="checkbox"/> Yes <input type="checkbox"/> Not Applicable
Proof of Extenuating Circumstance and/or Hardships (list below)	<input type="checkbox"/> Yes <input type="checkbox"/> Not Applicable



VIDEO & PHOTOGRAPHY CONSENT AND RELEASE FORM

I, _____, hereby give permission to Oracle Hearing Center, LLC/Hearing the Call – Central Jersey (hereafter HTC-CJ) to use and reproduce my image, likeness, voice, and name (collectively, “Image”) and to authorize others to use my Image in any manner HTC-CJ 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-CJ 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 Oracle Hearing Center, LLC/HTC-GH, 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 these 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.

Applicant/Representative Name (printed): _____

Applicant/Representative Signature: _____

Date: _____