Adult Hearing Services Application

The Georgia Charitable Care Network is a 501(c)(3) non-profit, non-governmental organization that provides hearing services with dignity and respect to uninsured, low-income people in Georgia.

The hearing aid package is not free. You will have a copayment. Individuals ages 20 years and older may apply once every three (3) years for services based on program funding. The household monthly net income must be within 200% of the federal poverty guideline (page 4).

PLEASE DETACH THE APPLICATION (PAGES 5-13) AND SUBMIT ONLY THE APPLICATION WITH COMPLETE DOCUMENTATION. DO NOT RETURN PAGES 1-4.
The estimated time to process your application is 4-6 weeks.

If you are unable or unwilling to provide the requested documentation, your application will not be approved. If complete documentation is not received within 3 months of initial submission, your application will be considered abandoned, and you will have to begin the application process over. You must wait 6 months to reapply.

Please send your application by MAIL OR FAX ONLY:

MAIL: The Georgia Charitable Care Network,
2897 N. Druid Hills Rd., #116, Atlanta, GA 30329
FAX: 866-329-8147

If sending by mail, DO NOT send by certified or priority mail.

Hours of operation for the Hearing Aid Dispatch Program:
Monday – Friday | 9:00 A.M. – 4:00 P.M.
Telephone: 888-551-1231

Application Requirements

In addition to a **completed** application, you must submit supporting documentation to prove your household income, identification, Georgia residency and unexpired hearing test with a GCCN provider.

Please submit COPIES ONLY, no original documents. Do not staple pages together.

The following MUST be submitted for this application to be considered: Failure to include these documents will delay your application and increase the time it takes to get approved. Patients are individually responsible for providing the required documents listed below.

1. **Proof of Georgia residency for at least 12 consecutive months.**
2. **Completed GCCN-approved Hearing Provider Recommendation (page 8).**
3. **Signed Medical Clearance or Medical Waiver (page 8).**
4. **Copy of a current hearing test, less than 6 months old, with a GCCN provider.**
5. **Completed application with attached supporting documentation.**

SUPPORTING DOCUMENTATION

1) <u>IDENTIFICATION:</u> ALL IDENTIFICATION CARDS MUST BE CURRENT (NOT EXPIRED) AND CLEARLY SHOW YOUR PHOTO. *(Please choose <u>one</u>)*

- Valid state issued driver's license
- Valid state issued identification card
- Passport
- School identification card
- Consulate identification card
- (Exception: Georgia Medicaid/Medicare card only accepted if 80+ years old and in a licensed nursing home.)

2) <u>RESIDENCY:</u> *(Please choose one)*

- Copy of current rental agreement including signature page
- Copy of most recent Mortgage statement
- Letter from shelter, transitional home, or nursing home stating that you live at that location (on letterhead and signed by shelter or transitional housing employee)
- Copy of a most recent utility bill, including the name of the applicant and service address, from either the applicant or member of household (Utilities only include: gas, water, and electric)
- Valid ID showing current address

3) <u>INSURANCE:</u>

<u>IF</u> your insurance provides coverage for hearing aids **<u>AND</u>** you are partially or fully insured by a high deductible insurance plan* send the following:

- Copy of your insurance Statement of Coverage, including the deductible

The Internal Revenue Service (IRS) definition of a "High Deductible Insurance Plan" is defined as any health plan with a deductible of at least $1,350 for an individual or $2,700 for a family.

4) <u>INCOME:</u>

Please send **ALL** the items from this list below that **<u>apply to you AND everyone in the household</u>**.

- Last year's tax return (1040)
- Two (2) current consecutive paycheck stubs for bi-weekly pay; or 4 current consecutive paycheck stubs for weekly pay
- Current Social Security/Disability Award letter
- Current Food Stamp award letter from Department of Family and Children Services (DFACS)
- Letter from nursing home (on letterhead and signed by nursing home employee)
- Letter from shelter (on letterhead and signed by shelter employee)
- Regular payments from alimony, child support, unemployment, union funds, retirement/pension, or other government programs funds
- College/university scholarship, grant, fellowship, or assistantship

IMPORTANT: Please be advised that we may request additional supporting documentation such as an official tax transcript. Contact the Internal Revenue Service (IRS) at 1-800-908-9946 to request a 4506-T Form for filing or non-filing transcript.

The applicant's household monthly net income cannot exceed 200% of Federal Poverty Guideline.

2023 Income Eligibility Chart
(According to the Federal Poverty Guideline)

Household* Size	0-100%	101-150%	151-200%
1	$1,215	$1,823	$2,430
2	$1,643	$2,465	$3,287
3	$2,072	$3,108	$4,143
4	$2,500	$3,750	$5,000
5	$2,928	$4,393	$5,857
6	$3,557	$5,035	$6,713
7	$3,785	$5,677	$7,570
8	$4,213	$6,320	$8,427
9	$4,142	$6,962	$9,383
10	$5,070	$7,605	$10,140

* Household is defined as a social unit comprised of spouses, parents, children, or relatives living in the same dwelling.

DO NOT SEND PAGES 1-4 WHEN SUBMITTING YOUR APPLICATION

Adult Hearing Services Application

(PLEASE PRINT CLEARLY WITH A DARK PEN)

Last Name: _____ **First Name:** _____ **MI:**_____

Address: _____

City: _____ **State:** Georgia **Zip Code:** _____

County of Residence: _____

Home Phone: _____ **Mobile Phone:** _____

Email Address: _____ ❑ I do not have an email address

Date of Birth:____ / _____/ ____ **Gender:** ❑ Male ❑ Female

Marital Status: ❑ Single ❑ Married ❑ Divorced ❑ Legally Separated ❑ Widowed
(You must provide official court documentation if divorced or legally separated)

Are you employed? ❑ Yes ❑ No **Are you a Veteran?** ❑ Yes ❑ No

If you are unemployed, please provide the reason:

❑ Disabled (receive SSI/SSDI) ❑ Retired ❑ Unable ❑ Lost Job ❑ Student ❑ Child ❑ Other

Race: ❑ White, not Hispanic or Latino ❑ Black or African American ❑ Asian

❑ American Indian or Alaskan Native ❑ Native Hawaiian or Other Pacific Islander

❑ Other Race ❑ Decline to Specify

Ethnicity: ❑ Hispanic or Latino ❑ Not Hispanic or Latino ❑ Decline to Specify

Please select the type of insurance coverage you have:

❑ Medicaid ❑ Medicare ❑ PeachCare ❑ Private ❑ Other ❑ None

Does your insurance plan include hearing aid coverage? ❑ Yes ❑ No

If yes, are you partially or fully insured by a high deductible insurance plan? ❑ Yes ❑ No

The Internal Revenue Service (IRS) definition of a "High Deductible Insurance Plan" is defined as any health plan with a deductible of at least $1,350 for an individual or $2,700 for a family.

How many years have you been a Georgia resident? _____

How did you hear about the Georgia Charitable Care Network?

❑ Georgia Charitable Care Network ❑ My Audiologist ❑ Advertising, Marketing, or Social Media

❑ Other Organization ❑ Other Source _____

Please complete ALL questions above in order for the application to be considered complete.

Financial Information

In the chart below, **list EVERYONE - including yourself - living at your address. Include proof of income for ALL members of the household**. Attach additional household members on separate sheet or list on the back of this page.

Name	Age	Relationship	Dependent (Yes or No)	Source(s) of Income	Amount of Monthly Income
		Self	No		$
					$
					$
					$
					$
					$
					$
					$
					$
Total Number of People in Household		*Total Number of Dependents in Household*		*Total Monthly Net Income (Combined income for all members of household)*	$

Provider Recommendation for: _____

Print Patient's Name

This section must be completed by the hearing professional who performed the hearing test.
You must include a copy of that current hearing test (audiogram).
The Georgia Charitable Care Network does not pay for hearing tests.

Business Name: _____

Name and Title of Hearing Professional: _____

Phone Number: _____Fax Number: _____

Address: _____ City: _____

State: _____ Zip Code: _____ Email Address: _____

Please specify degree of hearing loss: ❑ Mild ❑ Moderate ❑ Moderately Severe ❑ Severe ❑ Profound

Circle the type of hearing aids recommended and if an ear mold is required:

Right Ear: None RIC/BTE ITE BI CROS CROS Ear Mold: ❑ Yes ❑ No

Left Ear: None RIC/BTE ITE BI CROS CROS Ear Mold: ❑ Yes ❑ No

Do you require Medical Clearance for this patient? ❑ Yes ❑ No
If no, patient needs to sign medical waiver on the bottom of this page.

Is this facility a GCCN Provider? ❑ Yes ❑ No
If no, patient needs to follow instructions on Page 9.

If no, are you interested in becoming a GCCN Provider? ❑ Yes ❑ No

Contact us at 678-389-3333 or visit **www.charitablecarenetwork.org** for more information.

Medical Waiver

I have been advised by _____ (audiologist/hearing aid dispenser) that the Food and Drug Administration has determined that my best health interest would be served if I had a medical evaluation by a licensed physician (preferably a physician who specializes in disease of the ear) before obtaining a hearing aid. I choose not to have a medical evaluation before obtaining a hearing aid.

_____ ____/____/____
Signature of Applicant Date

Medical Clearance

I certify that _____ (applicant name) was medically examined on ____/____/____ and may be considered a candidate for hearing aid use.

• *Must be signed and dated by a licensed physician*

_____ ____/____/____
Signature of M.D.

_____
Name of M.D. (Please Print)

Georgia Charitable Care Network Statement Please read and sign.

REQUIRED

"I fully understand that the services of the Georgia Charitable Care Network are limited to residents unable to pay for, or receive from other sources, this assistance. In consideration of these services, I release and discharge all persons rendering such services from any claims I may have arising from the services rendered. I am aware that The Georgia Charitable Care Network will not pay for any hearing aids billed to me prior to approval of this application. I also understand that my application will be reviewed by a GCCN Provider, and/or The Georgia Charitable Care Network staff. ALL INFORMATION ON AND ATTACHED TO THIS APPLICATION IS TRUE AND CORRECT TO THE BEST OF MY KNOWLEDGE."

_____

Signature of Applicant (person applying for services) Date

_____

Witness (if applicant signs with an "X") Date

REQUIRED

HIPAA Agreement

I understand that the Federal Privacy Rule ("HIPAA") does not protect the privacy of information if re-disclosed, and therefore request that all information obtained by this person or agency be held strictly confidential and not be further released by the recipient. I further understand that my eligibility for GCCN services is not conditioned upon my provision of this authorization. I intend for this document to be a valid authorization conforming to all requirements of the Privacy Rule and understand that my authorization will remain in effect for one year.

_____

Signature of Applicant (person applying for services) Date

Complete this portion only if you would like to give us permission to speak with someone else on your behalf regarding your services.

Name: _____ Phone: _____

Relationship to Applicant: _____

Once completed, send your application and copies of all required documents to us by Mail, or FAX. If you have any questions, please call us at 888-551-1231.

Georgia Charitable Care Network Approved Hearing Providers

There are certain hearing providers who work with the Georgia Charitable Care Network (GCCN) hearing aid dispatch program. This means they accept payment from the Georgia Charitable Care Network on your behalf. It also means they abide by the guidelines of the Georgia Charitable Care Network program and agree to provide the services included in your hearing aid package.

For this reason, you MUST be a patient of a GCCN-approved hearing provider. A list can be found on our website, www.charitablecarenetwork.org by calling 888-551-1231.

What does this mean if you already have a hearing test? Can you use it?

Maybe. All hearing tests must be current. According to Georgia law, that means it must be 6 months old or less. Furthermore, if your hearing test does not come from a GCCN-approved provider, our GCCN providers may require you to get a new test from them before you can proceed to be their patient. If you have a current test you wish to use, you will need to ask your new GCCN provider if he/she will accept it.

How do you find a GCCN-approved hearing provider?

You can find a current list of providers at www.charitablecarenetwork.org, or you can call the Georgia Charitable Care Network at 888-551-1231 to request a list.

Once you have the list of providers, please follow these three steps:

1. Choose a GCCN Provider from the provided list.

2. Call the Provider you have chosen. Tell them that you are applying to The Georgia Charitable Care Network for hearing aid assistance and you need a GCCN-approved provider.

* If you have a hearing test that is less than 3 months old, ask them if they will accept it.

3. Ask the Provider if they are willing to accept you as a new patient. If the provider agrees to accept you as a patient, you will see this provider for your GCCN-approved hearing appointments.

* If the provider is not willing to accept you as a new patient, choose another provider from the list who is in your area and repeat the steps above.

Write name and address of your GCCN-approved hearing provider here:

_____

"By submitting this application, I agree to be bound by The Georgia Charitable Care Network's terms, conditions, and decisions regarding approval or denial. I understand that I am responsible for submitting in a timely fashion all supporting materials and that, if said materials are not received within ninety (90) calendar days of application submission, my application will be considered abandoned, necessitating the submission of a new application. I also agree to allow the use of my and/or my child's likeness (photograph) in any form of future program marketing and understand that, if I do not wish to consent to the use of said likeness, I must submit in writing a signed statement to that effect to be included in my application file."

_____

Signature of Applicant (person applying for services) Date