Pediatric Hearing Services Application & Info Packet

NEED HELP WITH THE APPLICATION?
GCCN partner Georgia Hands & Voices offers an assistive service, Guide by Your Side, for parents who could use a little help getting the application completed. Contact Scarlett Giles, GA H&V GBYS Program Director at sgiles@doe.k12.ga.us or 470-991-9187.

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 for your child is not free. You will have a copayment. Parents or legal guardians may apply once every three (3) years for services for their child (birth – 18 years) based on program funding. The household monthly net income must be within 400% of the federal poverty guide-line (page 4).

Please send your application by MAIL OR FAX ONLY:

MAIL: Georgia Charitable Care Network, 2897 N. Druid Hills Rd. #116, Atlanta GA 30329

FAX: 866-329-8147

DO NOT return application by certified or priority mail.

Hours of operation for the Hearing Aid Dispatch Program:
Monday – Friday I 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. Return only pages 5-13. No staples.

Revision Date: January 2023

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. The parents or legal guardian is responsible for providing these required documents:

1. **Completed GCCN-approved Hearing Provider Recommendation (page 8).**
2. **Signed Medical Clearance or Medical Waiver (page 8).**
3. **Copy of a current hearing test, less than 3 months old, with a GCCN provider.**
4. **Insurance summary of benefits showing denial or lack of coverage for hearing aid(s) and related (page 9).**

SUPPORTING DOCUMENTATION

1) IDENTIFICATION: ALL IDENTIFICATION CARDS MUST BE CURRENT (NOT EXPIRED) AND CLEARLY SHOW THE PARENT/LEGAL GUARDIAN'S PHOTO. ***(Please choose one for parents or legal guardian and one for child/applicant)***

- Valid state issued driver's license
- Valid state issued identification card
- Passport
- School identification card
- Consulate identification card (1 parent or legal guardian)
- Birth certificate

2) RESIDENCY: ***(Please choose one)***

- Copy of most recent Mortgage statement
- Letter from shelter, transitional home stating that you live at that location (on letterhead and signed by shelter or transitional housing employee)
- Valid ID showing current address

4) INCOME:

Please send documents from the list below that **apply to the parents/legal guardians AND everyone in the household.**

- Last year's tax return (1040)
- Current Social Security/Disability Award letter
- Current Food Stamp award letter from Department of Family and Children Services (DFACS)
- 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 parent/legal guardian's monthly household net income cannot exceed 400% of the Federal Poverty Guideline.

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

Household* Size	400%
1	$ 4,860
2	$ 6,573
3	$ 8,286
4	$ 10,000
5	$11,713
6	$13,426
7	$15,140
8	$16,853
9	$18,566
10	$20,280

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

Pediatric Hearing Services Application

(PLEASE PRINT CLEARLY WITH A DARK PEN)

Child's Information

Last Name: ____________________________ **First Name:** __________________________ **MI:**_______

Address: ____

City: _________________________________ **State:** Georgia **Zip Code:** _______________

County of Residence: ____

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

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

Primary Parent/Legal Guardian Information

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

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 ❑ Other

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

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.

Parent/Legal Guardian 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.

Medical Waiver

Child's Primary Diagnosis: ____

I recommend the following treatment(s): ____

Are there any medical barriers to treatment? ❑ Yes ❑ No

If yes, please list: ____

I certify that ______________________________ (applicant name) was medically

examined on _____/_____/_____ and may be considered a candidate for hearing aid use.
** Must be signed and dted by a licensed Physician (M.D.)*

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

____
Name of M.D. (Please Print)

Provider Recommendation for: ____

Print Patient's Name

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

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.

Insurance Affidavit
(Please PRINT)

This insurance affidavit must be completed by the hearing professional who performs the hearing test.

I, ____ (full printed name) declare under penalty of perjury that the following is true and correct to the best of my knowledge, information and belief.

Name of Practice: ____

Address: ____

I confirm that the following has been verified on the patient listed below:
Name of Patient: ____

❑ The patient is not covered by medical insurance.

❑ The patient is covered by medical insurance, but hearing services are not covered in the policy.

❑ Insurance summary of benefits.

A copy of this affidavit is being filed with GCCN in the designated hearing aid program filing system. Patient information will be kept on record for a minimum of three years. GCCN accepts the affidavit in good faith.

____ ____/____/____

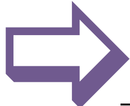
Signature of Provider Date

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 Parent/Legal Guardian Date

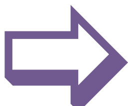
____

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.

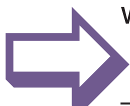


____

Signature of Applicant (person applying for services) Date

REQUIRED

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 Parent/Legal Guardian 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, 2897 N. Druid Hills Rd., #116, Atlanta, GA 30329 or FAX, 866-329-8147. 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.
* If you do not have a hearing test, tell them you need one

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.

Print the name and address of your GCCN-approved hearing provider who you have called to confirm:

____

“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 Parent/Legal Guardian Date