Dear Applicant,

Thank you for contacting Hearing the Call - Colorado 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.

Hearing the Call is a 501c3 nonprofit organization established to meet the hearing needs of low-income individuals. Hearing the Call - Colorado is a partnership between the below-referenced audiologists and Hearing the Call, and we serve those patients in our region. We provide hearing services for a reduced fee that will be determined on a sliding scale system based on the applicant's 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 Colorado 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. These criteria are outlined in this packet.

Please complete the following forms and return them, along with your supporting documents (including a current hearing test), per the instructions on the next page.

- Intake Form
- Demographic Information
- HIPAA Disclosure
- Eligibility Document Checklist
- Eligibility & 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 board 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 by leaving a message on our direct line at: 720-593-0898. You can also reach us by email at colorado@hearingthecall.org.

Sincerely,

Your Hearing the Call - Colorado Team

Chandace Jeep, Au.D.
Julie Eschenbrenner, Au.D.
Nichole Kovel, Au.D.
D'Anne Rudden, Au.D.
Julie Raney, M.S. CCC-A
Cory Workman, Au.D.
Dusty Jessen, Au.D.
Rachel McArthur, Au.D.

How to Submit Your Completed Application
(Please Choose ONE Method)

Fax: Columbine Hearing Care
720-669-8960

Mail: Columbine HearingCare
5808 S Rapp St, Suite 102
Littleton, CO 80120

Drop Off: Complete applications may be hand-delivered to one of our seven participating Entheos Audiology Cooperative audiologists' offices listed below. Office hours vary so please call the clinic to arrange a time to drop off your application.

Participating Entheos Audiology Cooperative Clinic Name	Phone Number	Address
New Leaf Hearing Clinic, Inc.	303-639-5323	8721 Wadsworth Blvd, Ste C **Arvada**, CO 80003
Animas Valley Audiology Associates	970-375-2369	799 E 3rd St, Ste 1 **Durango**, CO 81301
Flatirons Audiology, Inc.	303-664-9111	300 Exempla Circle, Ste 365 **Lafayette**, CO 80026
McArthur Audiology, LLC	719-346-5717	366 14th St **Burlington**, CO 80807
Columbine Hearing Care	720-689-7989	5808 S Rapp St, Ste 102 **Littleton**, CO 80120
Longmont Hearing and Tinnitus Center	303-651-1178	195 S Main St, Ste 8 **Longmont**, CO 80501
Elite Hearing of Colorado Springs	719-633-2685	4195 Centennial Blvd **Colorado Springs**, CO 80907
Community Hearing Center	970-586-5255	1186 Graves Ave, Unit B **Estes Park**, CO 80517

For specific questions about the application or eligibility please call 720-689-7989 and leave a message or email colorado@hearingthecall.org

Intake Form

Patient Name: _____ D.O.B. ___/___/_____ Age:____
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?

_____

1 2 3 4 5 6 7 8 9 10

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 all participating Entheos Audiology Cooperative Colorado offices and Hearing the Call - Colorado 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, INITIAL, AND SIGN BELOW **********

___ I give permission to all Entheos Audiology Cooperative Colorado offices 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 the individual participating Entheos Audiology Cooperative office where I am receiving my services.

___ I understand and agree that I am ultimately responsible for the balance of my account for professional services or purchases rendered. I understand that I may request documentation to submit to my insurance or health plan on my own and that participating Entheos Audiology Cooperative offices 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 participating Entheos Audiology Cooperative offices permission to treat my concerns.

I have read and understood 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 Prefer not to answer

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: _____ Not Specified

- ☐ I choose to provide only partial information above.
- ☐ I choose not to provide any information above.

INITIAL_____

Do you currently have hearing aids? Y / N

If yes, what kind?_____ **How old are they?**_____

HIPAA

Authorization to Use and Disclose Health Information

Patient Name: _____ Date of Birth: _____

I request and authorize participating Entheos Audiology Cooperative offices 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 participating Entheos Audiology Cooperative offices 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 participating Entheos Audiology Cooperative offices' 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 – Colorado web page and that I will have access to a copy of any amended Notice of Privacy Practices at each appointment.

This Notice informs me how participating Entheos Audiology Cooperative offices will use my health information for the purposes of my treatment and/or payment for my treatment. This Notice explains in more detail how participating Entheos Audiology Cooperative offices. may use and share my health information for other than treatment, payment, and health care operations. Participating Entheos Audiology Cooperative offices 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 participating Entheos Audiology Cooperative offices. 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 the project through Longmont Hearing and Tinnitus Center, 195 S. Main St. Suite 8, Longmont, CO 80501. 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 participating Entheos Audiology Cooperative offices' use and disclosure of my protected health information as described above. I understand that this authorization is voluntary and that participating Entheos Audiology Cooperative offices 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

Eligibility Document Checklist

Please make copies of the following items that apply to you and your household, and include them with your application packet. Please include documents for all adults over the age of 18 living in the household. Applications will only be reviewed when all of these documents have been received. Include only proof of social security/disability income if a child is under age 18.

Please circle Yes to indicate that the document is included in your packet OR No/Not Applicable for documents that do not apply.

Applicant Name:_____ DOB:_____

ITEM			NOTES
Intake Form (Both Sides)	Yes	No	
Current Audiogram (performed within the last 12 months)	Yes	No	
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/Spousal Support	Yes	Not Applicable	
Most Recent Income Tax Return (last 2 years)	Yes	Not Applicable	
Bank Statements / Checking & Savings Accounts (from the last 90 days)	Yes	Not Applicable	
IRA/Investment Income/401K/Stocks/Bonds/ Other Assets	Yes	Not Applicable	
Proof of Social Security or Disability Income	Yes	Not Applicable	
Proof of Unemployment Income	Yes	Not Applicable	
Proof of TANF, Financial Assistance Income, or Food Stamps	Yes	Not Applicable	
Proof of Extenuating Circumstance and/or Hardships (such as payments on medical bills)	Yes	Not Applicable	

Eligibility & Consent Form

Hearing the Call Colorado is available to children and adults diagnosed with hearing loss.

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

- Diagnosed with hearing loss in one or both ears. Current audiogram (hearing test) must be submitted with the application (must be performed within the last 12 months)
- Income not to exceed 250% above 2024 Federal Poverty Guidelines (see guidelines below)
- No more than $10,000 in cash reserves and/or savings
- 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.
- Ability to complete a total of 10 hours of community service

2024 Federal Poverty Guidelines

Household of 1:	$37,650.00	**Household of 5:**	$91,450.00
Household of 2:	$51,100.00	**Household of 6:**	$104,900.00
Household of 3:	$64,550.00	**Household of 7:**	$118,350.00
Household of 4:	$78,000.00	**Household of 8:**	$131,800.00

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 is truthful and accurate to the best of my knowledge.
3) I am not withholding any financial information that was requested as part of this Hearing the Call Colorado application.
4) I give consent to enroll and receive services through Hearing the Call Colorado, a partnership between participating Entheos Audiology Cooperative Colorado offices and Hearing the Call, a 501 (c) (3) organization.
5) I give consent to all participating Entheos Audiology Cooperative Colorado offices with Hearing the Call Colorado to view my personal financial information for the purpose of determining if I meet the eligibility requirements listed above.

_____ _____

Patient/ Guardian Name Date

_____

Patient/Guardian Signature