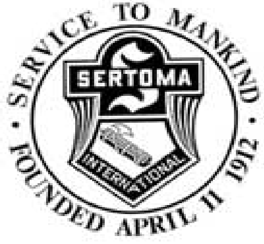

HEARS

Hearing Education & Assistance by Rocky Mountain Sertomans
2125 E. La Salle St, L-32
Colorado Springs, CO 80909

The HEARS Office is manned only on Thursdays 8:30 to 11:30 am.
HEARS Cell Phone: (719) 352-5124
(Leave a Message on the Cell Phone any time)

Dear Applicant:

Thank you for requesting an application for hearing aid assistance through Hearing Education & Assistance by Rocky Mountain Sertomans.

In 1988, H.E.A.R.S. was launched to provide hearing aids to low-income people who could not otherwise afford them. This program serves adults and children who reside in El Paso County. HEARS is mainly supported and funded by local SERTOMA clubs. When a used hearing aid is donated to the HEARS program, hearing aid manufacturers extend credit used for repair of hearing aids. You can find out more about donating faulty hearing aid(s) by calling (719) 352-5124. The HEARS Committee is proud to announce that over 2500 hearing aids and other services have been provided at little or no cost to qualifying clients through this program.

The following instructions will help you complete the application.

WE REQUIRE: Proof of income for each applicant, *and* all persons included in your "family size," unless a person is a dependant. **We *require* complete bank statements for the *last nine months*** (both checking and savings)**.** We require **proof of income** to verify your true financial need, and what you write in the financial section of this application. If you do not have bank accounts, you must write a letter detailing your reasons, and stating your monthly income. You must sign and date the letter and **have it notarized**. *****YOUR APPLICATION CAN NOT BE PROCESSED WITHOUT THESE*****

Enter any medical expenses that you paid for completely out of your pocket, during the last 12 months (We cannot include co-pays and premiums). This may include receipts for medications, vision, dental, etc. We will deduct these figures from your household income to better represent your adjusted net income. At this point the HEARS office will determine if you qualify for this program. Please note that over 90% of all applicants qualify for free hearing test and free hearing aids. We apply your annual adjusted income to a government sliding scale (Department of Health tables). The HEARS office pays 100% of cost for hearing aids; however, for those of you who do NOT qualify for 100% free hearing aids **you will be required to pay a co-pay in addition to your $20.00 application processing fee**. The dollar amount of the co-pay is determined from government income tables and the HEARS office does not have control of the results.

YOUR APPLICATION MUST BE SIGNED, DATED, AND NOTARIZED ON THE "RELEASE" PAGE.

Once you complete the application and provide the necessary documents **you can** mail it to the address above. When your application is processed you will be notified of the results by letter. If your application is approved you will be required to pay the nonrefundable processing fee of $20.00. After your enrollment fee is received, you will be assigned to an audiologist in Colorado Springs. You will be responsible for making your appointment with the assigned audiologist. **For Those of you who are required to pay a co-pay**, **You** will be assigned to a HEARS audiologist when the $20.00 and co-pay are received in the HEARS office.

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APPLICATION FOR HEARING AID ASSISTANCE

PLEASE READ THROUGH AND COMPLETE ALL PAGES **DATE: ____________________**

How did you hear about our program? Referred by (Name, Organization, Phone Number):

____

What are your hearing needs? ____

____.

Have you ever been through the HEARS program ?Yes ☐ **No** ☐

Your (Applicant's) Name: ____

D.O.B.: ________________ **Age:** ______________**Sex: Male** ☐ **Female** ☐

County of Residence: ____________________ **U.S. CITIZEN: Yes** ☐ **No** ☐

Address:____

City:_______________________________________ **State:**______ **Zip Code:**_______________

Your E-mail: _________________________________

Primary Phone#: (____)____________________ **Other Phone#: (____)**__________

Employer: ______________________________ **Work Phone#: (____)**__________

Emergency Contact: _____________________ **Their Phone#: (____)**___________

Relationship:___________________________ **(Daughter, Brother, Friend, etc.)**

Have you been to an audiologist or hearing clinic for evaluation? **Yes** ☐ **No** ☐

If yes, name____

YOU MUST PROVIDE COMPLETE PROOF OF INCOME
OR THIS APPLICATION CAN NOT BE PROCESSED

We require nine months of bank statements to verify your financial need. We also require most recent Social Security Statement of Benefits if available and/or most recent W2s , or pay statements.
If you do not have bank accounts, you must write a letter to this effect, and state your monthly income, then sign it and have it notarized. We also require other proof of income (i.e. your Social Security statement, paycheck stubs, retirement statement, W2s etc).
*****YOUR APPLICATION CAN NOT BE PROCESSED WITHOUT THESE*****

Family Size ___________(People living in the household)

Applicant's Monthly Income $_________________ Source: ________________ (i.e. employment, Social Security, SSI, pension, retirement, etc)

Applicant's Additional Monthly Income $_____________________Source: _____________ (i.e. employment, Social Security, SSI, pension, retirement, etc)

Other Family Members' Monthly Income $____________________Source:________________ (i.e. employment, Social Security, SSI, pension, retirement, etc

TOTAL MONTHLY HOUSEHOLD INCOME: $ ____________________

Yearly Medical Expenses $ ________________ (Excluding co-pays and Insurance premiums)

***Attach copies of receipts for the past 12 months: Prescriptions, dental expenses, vision expenses, etc.**

For Office Use Only

Total Yearly Income (income less medical expenses):	______________________
Percent Discount Assigned:	______________________
Processing Staff Approval:	______________________

RELEASE

I certify that the information I have given is true and accurate to the best of my knowledge. Further, I will make available to the appropriate provider information regarding my medical insurance (Medicaid, Medicare, or private insurance) which will be used to bill for the ENT services. I understand that I am responsible for ENT charges which are not covered by the HEARS program nor my insurance. I will be informed of the percentage covered by the HEARS program prior to the charges being incurred.

I understand that this application is made so that the HEARS program can determine my eligibility for the uncompensated services (under the Hill-Burton Act) based on the established criteria on file. If any information I have provided is found to be fraudulent, I understand that the HEARS Committee may re-evaluate my financial status and take whatever action is deemed necessary.

I authorize the HEARS program to collect and release information related to my hearing problem from any past or current provider.

I hereby release SERTOMA, and the HEARS program from any liability in furnishing needed information.

I have applied for funding assistance and/or services through the HEARS program, which is a collaborative program of the Southern Colorado SERTOMA Clubs.

All services will be performed by professional vendors and HEARS providers. I agree to hold harmless all those associated with the HEARS program from any claims arising through the services and/or equipment provided by this program.

______________________________________ ___________________
Applicant's Signature (or parent/guardian) Date
(MUST BE SIGNED and dated IN THE PRESENCE OF A NOTARY)

The information on this application and the above release has been subscribed

and affirmed, or sworn to before me in the county of ________________________________

State of Colorado, this ______________ day of ____________ 20________.

______________________________________ _______________________
Notary Signature **Commission Expiration Date**