



HEARS of El Paso County
2125 E. La Salle St, L-32
Colorado Springs, CO 80909

The HEARS office is not open for visits. All correspondence is via mail or phone.

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 by local SERTOMA clubs 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. Although now a separate 501c3 non-profit, 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. HEARS is proud 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). If you qualify HEARS 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 need to** 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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The HEARS Office is manned only on Thursdays 8:30 to 11:30 am.
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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 \$ _____ ***Attach copies of receipts**
(Excluding co-pays and Insurance premiums) **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 services. I understand that I am responsible for 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 HEARS of El Paso County, HEARS, the program and all volunteers and services providers from any and all liability in furnishing needed information.

I have applied for funding assistance and/or services through the HEARS program, which is a 501(c)(3) non-profit registered with the IRS and State of Colorado.

All services will be performed by volunteer 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. I also agree to verbally and physically conduct myself in a respectful manner with service providers and HEARS volunteers and acknowledge that my failure to do so may subject me to having my participation in the program withdrawn. I acknowledge that any funds paid by me will therefore be forfeited in the event of my participation being withdrawn.

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