HEARS of El Paso County
8595 Explorer Drive
Colorado Springs, CO 80920

The HEARS office is not open for visits. All correspondence is via mail or phone.
HEARS Cell Phone: (719) 352-5124
(Leave a short clear 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 are citizens of the USA and reside in El Paso County. Although now a separate 501c3 non-profit, HEARS is mainly supported and funded by local SERTOMA clubs. Used hearing aid can be donated to the HEARS program, then hearing aid manufacturers extend credit used for repair of hearing aids. To donate used hearing aids call (719) 352-5124. HEARS is proud that over 2600 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 six months*** (both checking and savings)**.** We require **proof of income** to verify your true financial need, and what information you provide 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 major medical expenses that you paid directly 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 and Human Services tables). Once you qualify, HEARS can pay up to 100% of cost for hearing aids; there is also a maximum income above which there is zero subsidy available. For those who qualify financially but are below the maximum income (i.e. you do not qualify for 100% free hearing aids) **you will be required to pay a co-pay.** 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. HEARS no longer requires a registration fee but donations of $20 or more are encouraged.

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 who are required to pay a co-pay you** will be assigned to a HEARS audiologist after the co-pay is received in the HEARS office.

HEARS maintains privacy on all information (personal, financial and medical) provided to us, but utilizes said information as described in this application and as provided for on the Release page.

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APPLICATION FOR HEARING AID ASSISTANCE **Note: The HEARS program is governed by our charter, and is available to all US Citizens and residents of El Paso County, Colorado who qualify financially.**

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 ☐ Prefer not to say ☐

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

Address:_____

City:_____State:_____Zip Code:_____

Your E-mail: _____

Primary Phone# to contact you: (_____)

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_____

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

We require six (6) 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 $_____ *Do not attach copies; (if we want them we will ask for them)

For Office Use Only

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

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I Acknowledge that by Signing this RELEASE I hereby:

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 any charges being incurred.

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.

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

Hereby release HEARS of El Paso County, HEARS, the program and all volunteers and services providers from any and all liability in furnishing any and all needed information.

Acknowledge I have applied for funding assistance and/or services through the HEARS of El Paso County, DBA HEARS, program, which is a 501(c)(3)non-profit registered with the IRS and State of Colorado serving US citizens and residents of El Paso County, Colorado.

Understand that all services will be performed by volunteer professional vendors and HEARS providers who are donating a portion or all of their costs and time. I agree to hold harmless all those associated with the HEARS program from any and all claims arising through the services and/or equipment provided by this program.

Agree to verbally and physically conduct myself in a respectful manner with service providers and HEARS volunteers. I acknowledge that my failure to do so may subject me to having my participation in the program withdrawn at the sole discretion of HEARS. I understand and acknowledge that any funds paid by me will be forfeited in the event of my participation being withdrawn.

_____ _____
Applicant Printed Name Date

_____
Applicant's Signature (or parent/guardian)
(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**