Dear Applicant,

Thank you for contacting Hearing the Call – Rocket City 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 – Rocket City is a partnership between Hearing the Call, a 501c3 nonprofit organization, and Alabama Hearing Associates, established to meet the hearing needs of low-income adults in North Alabama. We provide hearing services for a reduced fee based on the applicant's household size and income. Our goal is to make quality hearing care more affordable and accessible to adults in need. This assistance comes through donations from audiologists and other donors across Alabama and the US. We ask all participants to pay this generosity forward through volunteer hours at their charity of choice.

To qualify for our program, you must meet certain financial criteria based on Federal Poverty Guidelines. Please take a few moments to review this packet, which includes documentation requirements for the application. Simply complete the following forms and return them, along with your supporting documents, to either of our convenient locations.

- Intake Form
- Demographic Information
- Eligibility Document Checklist
- Eligibility & Consent Form
- Video & Photography 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 team 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 at 256-319-4327 x3 or email laura@alabamahearing.net.

Sincerely,

Alabama Hearing Associates & Hearing the Call – Rocket City
www.alabamahearing.net
8075 Madison Blvd. Ste. 108, Madison, AL 35758
4205 Balmoral Drive, Ste. 201, Huntsville, AL 35801

Applicant Name: _____ Date of Birth: ____/____/____
First Last MI MM DD YYYY

Referred By: _____

Contact Information:

Mailing Address: _____

Home Phone: _____ Cell Phone: _____ Work Phone: _____

Email Address: _____

Personal Information:

SSN: _____ Gender Identity: M F Other

Occupation: _____ Employer: _____ N/A

How many people live in your Household?: _____ Marital Status: _____

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:

Name: _____ Relationship: _____ Phone #: _____

Primary Care Physician: _____ City: _____ Phone: _____

Insurance Type:

- ❑ None
- ❑ Medicaid
- ❑ Medicare
- ❑ Other

Non-Discrimination Policy: It is the commitment and policy of Alabama Hearing Associates and Hearing the Call – Rocket City that we do not discriminate against any person based on 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.

Eligibility & Consent Form Revised 9/14/2023

Hearing the Call – Rocket City is available for adults in Alabama who have been diagnosed with a hearing loss. The following eligibility requirements must be met to enroll in this project:

- Diagnosed with hearing loss in one or both ears
- Income not to exceed 250% above the federal poverty level
- Must not have private health insurance benefit for hearing aids
- Live within the state of Alabama. Applicants who live outside the state of Alabama may be considered on a case by case basis.
- Ability to complete a total of 10 hours of community service

Household of 1:	$36,450.00	**Household of 5:**	$87,750.00
Household of 2:	$49,300.00	**Household of 6:**	$100,700.00
Household of 3:	$62,150.00	**Household of 7:**	$113,550.00
Household of 4:	$75,000.00	**Household of 8:**	$126,400.00

You may have no more than $10,000 in cash reserves and/or savings

You may have 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.

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 for program eligibility was truthful and accurate to the best of my knowledge.
3. I am not withholding any requested financial information that was requested as part of the program application.
4. I give consent to enroll and receive services from Alabama Hearing Associates and Hearing the Call – Rocket City, in collaboration with Hearing the Call, a 501c3 organization.
5. I give consent to allow Alabama Hearing Associates and all individuals associated with Hearing the Call – Rocket City to view my personal financial information for the purpose of determining if I meet the financial eligibility requirements.

Applicant/Representative Name: _____

Applicant/Representative (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 Other

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: _____

☐ I choose to provide only partial information above.

☐ I choose not to provide any information above.

INITIAL_____

Eligibility Document Checklist

Applicant Name: _____ **DOB:** _____

Please make copies of the following items that are applicable to you and your household and return them to our office within 90 days. Please include documents for all adults over age 18 living in the household. Include only proof of social security/disability income if a child is under age 18.

ITEM	NOTES
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 Support/Spousal Support	❑ Yes ❑ Not Applicable
Most Recent Income Tax Return (last two years)	❑ Yes ❑ Not Applicable
Bank Statement (from the last 60 days)	❑ Yes ❑ Not Applicable
IRA/Investment Income/401K/Stocks/Bonds or other assets	❑ Yes ❑ Not Applicable
Proof of Residence (utility bill, lease, or other)	❑ Yes ❑ Not Applicable
Proof of Social Security or Disability Income	❑ Yes ❑ Not Applicable
Proof of Unemployment Income	❑ Yes ❑ Not Applicable
Proof of Financial Assistance Income, or Food Stamps	❑ Yes ❑ Not Applicable
Proof of Extenuating Circumstance and/or Hardships (list below)	❑ Yes ❑ Not Applicable

_____

_____

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_____

_____

Media Release and Hold Harmless Agreement

I, _____[Patient Name], hereby grant permission to _____[Private Practice], Entheos Audiology Cooperative, Inc., Agents, Assigns, & Licensees of Entheos Audiology Cooperative, and Hearing the Call, Inc. (collectively hereinafter referred to as "Media"), to use, reproduce, edit, modify, and distribute my image, likeness, voice, and name (collectively hereinafter referred to as "Image") in any manner that Media elects, including but not limited to print publications, web sites, social media, audio-visual broadcasts, advertisements, and promotional materials. I understand that Media shall own all rights in and to my Image, including all rights under copyright.

I expressly waive any right I might have to prior approval over how and where my Image is used and any claims for compensation or rights of privacy under any Federal or State statutes. I understand that this release is intended to cover all uses of my Image by Media, its affiliates, successors, assigns, and licensees.

By signing below, I forever release, discharge, and hold harmless Media, their respective officers, employees, agents, representatives, and other persons acting within the scope of their authority, from any and all claims, demands, liabilities, causes of action, costs, and expenses, now known or later discovered, arising out of or in connection with the use of my Image. This includes, but is not limited to, claims for invasion of privacy, misappropriation, right of publicity, defamation, or any other claim arising from the use, editing, distribution, or exploitation of my Image.

I understand that this Agreement shall be governed by and construed in accordance with the laws of Indiana. Any disputes arising out of or in connection with this Agreement shall be subject to the exclusive jurisdiction of the courts of Indiana. I acknowledge that I have read and understood the entire contents of this Media Release and Hold Harmless Agreement. I have had the opportunity to seek legal counsel and ask questions prior to signing this Agreement.

If applicable:

- I am at least 18 years of age and have the legal capacity to enter into this Agreement on my own behalf.

  OR

- I am the parent/legal guardian/POA of the above-named individual, and I have the authority to sign this Agreement on their behalf. I have read and understood the entire contents of this Agreement and had the opportunity to seek legal counsel and ask questions prior to signing.

Signature: _____ Date: _____

Name (please print): _____

Relationship to Patient: _____ (Example: Self, Parent, or Legal Guardian)