

## **Community Hearing Aid Program, Inc.**

### **Instructions for Hearing Aid Services**

Thank you for applying for hearing assistance through the Community Hearing Aid Program, Inc. This program provides over 400 hearing aids to low-income, hearing impaired persons every year by utilizing the pro bono services of over 85 hearing health care providers in Arizona. CHAP uses both new and refurbished In-The-Ear and Behind-The-Ear hearing aids. The hearing aids range in technology from analog to high end digital hearing aids. If approved, the highly experienced CHAP provider will determine the most suitable hearing aid for your hearing loss and lifestyle.

This program is designed for those who do not have any other resource to help them. CHAP is a program of last resort. Other options for assistance include family support, insurance, Vocational Rehabilitation, Child Rehabilitation Services, school district and the Veterans Administration. This is **not** an annual benefit. Applicants must wait 3 years before applying for new hearing aids after previously being fit through CHAP, Inc. CHAP will pay for all authorized repairs to hearing aids issued through the organization. In the event that a hearing aid is no longer repairable, a new application and application fee must be made to obtain a replacement hearing aid. One package of hearing aid batteries will accompany the hearing aid, however additional batteries are the responsibility of the wearer. CHAP is an Arizona based charity and hearing aids are only provided to approved applicants who legally reside in Arizona and fit within the income and audiological restrictions.

*In order to process your application, please be sure to include:*

- 1) Completed & Signed application
- 2) Proof of **household** income (COPY of recent bank statement, Social Security award letter, tax return, pay stub) If the applicant is married, the spouse's income, disability, retirement or SSI must be included. This information is destroyed after eligibility has been determined)
- 3) Comprehensive hearing evaluation performed by an AUDIOLOGIST within 6 months of the application date. This is the applicant's financial responsibility and applications will not be reviewed without a current evaluation attached
- 4) Medical clearance, signed by a Physician -OR- Medical waiver signed by the applicant
- 5) Application Fee of \$75.00 for one hearing aid, \$150 for two hearing aids (Money Order or Certified Check ONLY!!!). The application fee is not considered payment for the hearing aid or for the services provided. Therefore, it may be tax deductible and is non-refundable. A receipt for the application fee will be mailed to you along with your eligibility determination.
- 6) Proof of Legal residency (COPY of your Social Security Card -OR- COPY of your Passport -OR- Certified Copy of your birth certificate -OR- COPY of your Medicare card -OR- COPY of your Green Card or other documentation of legal status)
- 7) Signed records release and binaural waiver if you are applying for only one hearing aid

Incomplete applications will not be reviewed and will be returned to you. This will delay the process of obtaining services significantly and a re-processing fee of \$10 will be assessed to your application! Due to patient privacy issues, health information can not be requested by CHAP. The information must be obtained by you and sent with your application. Do not submit the application without all the information attached and the \$75.00 per hearing aid application fee.

**Mail all information and application fee to:**

Community Hearing Aid Program, Inc.  
3434 West Anthem Way, Suite 118 #486  
Anthem, Arizona 85086

# Application for Hearing Aid Services

Date: \_\_\_\_\_

Applicant Name: \_\_\_\_\_ Age: \_\_\_\_\_

Social Security Number: \_\_\_\_\_ Family Size: \_\_\_\_\_

Address: \_\_\_\_\_

City, State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Phone Number: \_\_\_\_\_

*If you do not have a phone, or do not speak English; please list another person whom we may contact who will be able to assist you during the application process:*

Name: \_\_\_\_\_

Phone Number: \_\_\_\_\_

Health Insurance: \_\_\_\_\_

Does your health insurance have any hearing aid benefits? YES / NO If so, what is the benefit?

\_\_\_\_\_

Have you received a hearing aid from the CHAP, Inc. in the past? YES / NO

Do you now have, or have you ever had a hearing aid? YES / NO

Please explain your need for new amplification \_\_\_\_\_

\_\_\_\_\_

If you currently wear a hearing aid, please indicate the number of hours per day you wear the hearing aid: \_\_\_\_\_

## Financial Information

### Gross HOUSEHOLD / FAMILY Income

*(If applicant is a minor, list parent's income)*

Amount per month: \_\_\_\_\_ Source: \_\_\_\_\_

Amount per month: \_\_\_\_\_ Source: \_\_\_\_\_

**Total monthly income :** \_\_\_\_\_

**Expenses**

Expenses Monthly Rent/Mortgage: \_\_\_\_\_

Estimated monthly Utilities: \_\_\_\_\_

Monthly "Out of Pocket" medical expenses: \_\_\_\_\_

Other Expenses: \_\_\_\_\_

**Total monthly expenses:** \_\_\_\_\_

Please list any other factors that we should consider when determining your eligibility for CHAP assistance (use an additional page if necessary): \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

*By signing below, you affirm that the information contained within this application is current and complete. You also understand that if you qualify to receive a hearing aid through CHAP, the hearing aid remains the property of CHAP and all authorized repairs will be paid for by CHAP. You are entitled to keep the hearing aid as long as you are using it on a daily basis and your financial situation or residency in Arizona has not changed since submitting this application. If a change of address, hearing aid usage or a change in income occurs, please notify CHAP immediately. Additionally, I grant permission to the Community Hearing Aid Program, Inc. to release all medical records pertaining to my hearing disorders to the assigned CHAP hearing aid provider for the purposes of hearing aid selection and fitting.*

**Applicant Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

*CHAP, Inc. reserves the right to verify any information contained within this application*

**Binaural Hearing Aid Waiver**

It has been determined that the use of 2 hearing aids for binaural hearing loss provides the best hearing results. There is evidence to suggest that the use of one hearing aid can cause auditory deprivation in the unaided ear and the unaided ear may deteriorate at a faster rate than the aided ear. Please sign below if you would like to proceed with receiving one hearing aid rather than two aids.

**(Do not sign this waiver if you are requesting 2 hearing aids)**

**Print Name:** \_\_\_\_\_

**Patient Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

Either patient signs the Medical Waiver **OR** your Dr. signs the Medical Clearance

Doctor's Medical Clearance

Medical Clearance (This can only be signed by a physician! This can NOT be signed by an Audiologist, Nurse or Hearing Aid Dispenser.)

Patient Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

**Please check one statement:**

\_\_\_\_\_ This patient's hearing loss has been medically evaluated and he/she may be considered a candidate for a hearing aid.

\_\_\_\_\_ I do not recommend that this patient be fitted with a hearing aid at this time.

Comments: \_\_\_\_\_

Physician Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Physician name (Print): \_\_\_\_\_

Physician Address: \_\_\_\_\_

Physician Phone Number: \_\_\_\_\_

Patient Medical Waiver

*If you are over 18 years of age, and do not wish to have a medical evaluation, please read and sign the statement below. If your doctor has signed the Medical Clearance, you do not need to sign this.*

I have been advised by my CHAP dispenser that according to the Food and Drug Administration (FDA), it is in my best health interest to be examined by a physician (preferably one specializing in hearing loss and diseases of the ear), prior to purchasing a hearing aid. I have elected not to have the suggested examination and I am over the age of 18.

Patient Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Print Name: \_\_\_\_\_