Audiology Patient Assistance (APA) Program Application

The Audiology Patient Assistance (APA) program is administered by the Department of Audiology at Cleveland Hearing & Speech Center. This program provides hearing aids, assistive listening devices, hearing aid accessories, earmolds, hearing aid repairs and/or professional services on a sliding fee scale to low-income, qualified individuals in the Northeast Ohio area. Eligibility for the program is based on the completion of an application and proof of income, submitted by the patient. ALL FEES PAID ARE NON-REFUNDABLE. **Please be advised that we cannot process your application without proof of financial status.** Please allow 4 weeks to process your application. A waiting period may be required before you can obtain your hearing aid and/or assistive listening device depending on our current grant funding for the program.

Hearing Aid Program
Hearing aids are provided at a significantly reduced cost compared to the CHSC retail price (fees cover services related to fitting the hearing aids). Repairs after the warranty period will be the financial responsibility of the patient. After the initial fitting, there may be additional charges to the patient for any services provided by the clinician. Depending on our funding, we may be able to provide 1 or 2 hearing aids per patient.

All fees are DUE IN TOTAL at the time of the hearing test/hearing aid consult visit and are NON-REFUNDABLE. We provide services on a sliding scale. If accepted into the program, typical charges range from $70—$1000.

Approval into the Audiology Patient Assistance program will be canceled if another funding source is used for payment. In addition, if an insurance benefit for hearing aids becomes available, acceptance into the program will no longer be valid. CHSC adheres to the same hearing aid eligibility guidelines used by Ohio Medicaid.

Assistive Listening Device/Hearing Aid Accessory Program
Assistive listening devices and hearing aid accessories are provided at a significantly reduced cost compared to the CHSC retail price (fees cover services related to ordering and dispensing the devices). Devices may or may not come with a manufacturer's warranty. Warranty information will be explained at the dispensing visit. CHSC does not do installations of any assistive listening device or hearing aid accessory. It is the patient's responsibility to arrange for installation of the product. Installation costs are not covered by any of the fees paid to CHSC.

All fees are DUE IN TOTAL at the first visit and are NON-REFUNDABLE. Most devices are special ordered and will require returning to CHSC for a second visit. If accepted into the program, there is a minimum $25 charge (actual fee may be higher depending on devices ordered).

Hearing Aid Repair Program
The APA program may also be able to provide hearing aid repairs, earmolds and loss/damage replacement fees on a sliding fee scale. All fees are DUE IN TOTAL before we can complete an order. If accepted into the program, typical charges range from $25-$50 per repair, earmold or replacement fee.

Professional Services for Hearing Aids
We can provide hearing aid services such as hearing aid clean/checks and hearing aid programming on a sliding fee scale. If accepted into the program, typical charges range from $20-$50. All fees are DUE IN TOTAL at the time of visit.

Questions regarding the Audiology Patient Assistance Program should be directed to the Department of Audiology at 440-455-9898.

Mail application and proof of income to:
Cleveland Hearing & Speech Center
29540 Center Ridge Rd. Suite B
Westlake, OH 44145

Email to:
intake@chsc.org

CLEVELAND Hearing & Speech CENTER℠

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Date received _____ Date reviewed _____

I hereby request that Cleveland Hearing & Speech Center make a written determination of my eligibility for the APA program. I understand that the information I submit concerning my income and family size is subject to verification by CHSC. I also understand that if the information is found to be false, such a determination will result in a denial of products and services, and that I will be liable for the full fee of services provided.

What are you applying for (check all that apply):

- ○ Hearing aid
- ○ Hearing aid repair
- ○ Listening device (hearing aid accessories, amplified phone, alerting devices, etc.)
- ○ Professional services (hearing aid clean/check, programming, dispensing, etc.)

NAME _____

ADDRESS _____

CITY_____ STATE _____ ZIP _____

PHONE _____ BIRTH DATE _____ Email address _____

MEDICAL INSURANCE _____ *(please provide a copy of your current insurance card)*

Ethnicity: ○ White ○ Black ○ Asian ○ Hispanic/Latino ○ Native American ○ Biracial ○ Other
(for reporting purposes only, our grant funders request certain demographic information about our applicants)

FAMILY SIZE: Please list all people currently living in your home.

NAME	AGE	RELATIONSHIP

INCOME: Please list monthly income for all people listed above.

Wages (including self employment)	_____
Social Security	_____
Pensions	_____
Public Assistance	_____
Other Sources of Income (including unemployment, worker's compensation, alimony, child support, income from interest or dividends)	_____
GRAND TOTAL	_____
Current balance of Savings/Checking Accounts	_____

You must submit documentation of the above stated income. Accepted documentation include:

1. Wage statement (e.g. social security, unemployment, public assistance, pension, etc.)
2. Bank statement
3. Social Security statement

Amounts listed above should match the documentation provided. If the amounts do not match, you may be asked to provide additional documentation.

We cannot process your application without this information!

Are there any circumstances we should know about regarding support you may receive from family members?

_____

_____

Please indicate any unusual circumstances that you believe should be taken into consideration in determining your eligibility for this program including medical expenses, prescriptions, etc. (please provide documentation if possible)

_____

_____

Have you had your hearing tested in the past 6 months?

◯ Yes. **Please attach a copy of the hearing test.** If you do not attach the test, we will have to repeat the evaluation and there will be an additional fee for this service.

◯ No. CHSC adheres to the same hearing aid eligibility guidelines used by Ohio Medicaid. If a current hearing test is not sent with this application, eligibility for hearing aids through the APA program will be determined conditional until testing is completed.

I affirm that the preceding information is true and correct to the best of my knowledge. I acknowledge that approval into the Audiology Patient Assistance program will be canceled if another funding source is used for payment. In addition, if an insurance benefit for hearing aids becomes available, acceptance into the program will no longer be valid.

_____ date signed _____

signature of person making request

If application is completed by someone other than the patient, please let us know who you are.

Name _____ Phone _____

◯ If correspondence should go to you, please provide address and phone number.

Address _____ City _____ ST _____ Zip _____

How did you hear about this program?

Name _____ Phone _____

Address _____ City _____ ST _____ Zip _____

Do we have permission to contact this person regarding your application? YES ○ NO ○

Please return application and proof of income to:
CHSC ● 29540 Center Ridge Rd. Suite B ● Westlake, OH 44145 ● 440-455-1999 Fax
Email completed application to intake@chsc.org

*****If your application is more than 5 pages, please mail with appropriate postage (2 stamps)*****

Please allow 4 weeks to process your application.