



# 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 and/or hearing aid repairs 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. **Please be advised that we can not process your application without proof of financial status.** Please allow 4 weeks to process your application. A waiting period, of undetermined length, may be required before you can obtain your hearing aid and/or assistive listening device.

## Hearing Aid Program

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 cannot be determined until testing is completed.

While there is no charge for the hearing aid itself, there will be charges for professional services rendered including testing as necessary. 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 audiologist. 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/ear impression visit and are NON-REFUNDABLE. We provide services on a sliding scale. If accepted into the program, typical charges range from \$56 to \$873. Remember, charges are for services only, the hearing aid itself is given at NO CHARGE. **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.

## Hearing Aid Repair Program

We can assist with hearing aid repair charges. All fees are DUE IN TOTAL before we can send the hearing aid to the manufacturer for repair.

## Assistive Listening Device Program

While there will be no charge for the device(s) themselves, there will be charges for professional services rendered (including audiologic testing as necessary). Devices may or may not come with a manufacturer's warranty. Warranty information will be explained at the dispensing visit. CHSC does not handle repairs of assistive listening devices. The patient is responsible for sending any malfunctioning product back to the manufacturer. CHSC does not do installations of any assistive listening device. 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. We provide services on a sliding fee scale. If accepted into the program, typical charges range from \$14 to \$140. Remember, charges are for services only, the assistive listening device(s) are given at NO CHARGE.

**Questions regarding the Audiology Patient Assistance Program should be directed to the Department of Audiology at 440-838-1477.**

Return application and proof of income to:

Cleveland Hearing & Speech Center  
7000 Town Centre Dr. Suite 200  
Broadview Heights, OH 44147



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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
- Assistive listening device (such as amplified phone, TTY, alerting devices, etc.)

NAME \_\_\_\_\_

ADDRESS \_\_\_\_\_

CITY \_\_\_\_\_ STATE \_\_\_\_\_ ZIP \_\_\_\_\_

PHONE \_\_\_\_\_ BIRTH DATE \_\_\_\_\_ PHYSICIAN \_\_\_\_\_

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!***

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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 • 7000 Town Centre Dr. Suite 200 • Broadview Hts. OH 44147 • 216-325-7620 Fax**  
**We cannot process your application without proof of income!**

\*\*\*\*\*  
Office Use Only:  
 Has HAP file. Office/Location \_\_\_\_\_  
 Repair charge: \_\_\_\_\_  
 ALD consult completed. Date \_\_\_\_\_ CHSC Rep \_\_\_\_\_ Devices needed \_\_\_\_\_

*Please allow 4 weeks to process your application.*