Dear Applicant -

Thank you for contacting Hearing the Call - Colorado 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 is a 501c3 nonprofit organization established to meet the hearing needs of low-income individuals. Hearing the Call - Colorado is a partnership between the below-referenced audiologists and Hearing the Call, and we service those patients in our region. We provide *hearing aids* and *hearing aid services* at either a reduced fee or at no charge based on the applicant's household size and income. There will be a $150 fitting fee collected at the time of hearing aid fitting. Our goal is to help make hearing care more affordable and accessible to our community members. This assistance comes through donations from audiologists as well as donors across Colorado and the United States. We ask all participants to pay this generosity forward through the commitment of volunteer hours at their charity of choice.

You must meet certain financial criteria based on Federal Poverty Guidelines to qualify for our program. These criteria are outlined in this packet.

Please complete the following forms and return them - along with your supporting documents (including a current hearing test) - per the instructions on the next page.

- Intake Form
- Demographic Information
- Eligibility Document Checklist
- Eligibility & Consent Form

Your privacy is of utmost importance to us and these documents are only viewed for eligibility determination. You will receive notification and further instructions once the documents have been reviewed and a decision has been made by our board. 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 by leaving a message on our direct line (720-706-5126) or by email at: colorado@hearingthecall.org.

Sincerely -

Your Hearing the Call - Colorado Team

Chandace Jeep, AuD | D'Anne Rudden, AuD | Dusty Jessen, AuD
Julie Eschenbrenner, AuD | Julie Raney, M.S. | Rachel McArthur, AuD

How to Submit Your Completed Application

(Please select only ONE method)

1. **Email**: colorado@hearingthecall.org

2. **Fax**: Columbine Hearing Care
   Attn: Lisa
   720-669-8960

3. **Mail**: Columbine Hearing Care
   5808 S Rapp St., Suite 102
   Littleton, CO 80120

4. **Drop Off**: Completed applications may be hand-delivered to one of our seven participating Entheos Audiology Cooperative audiologists' offices listed below. Office hours vary, so please call the clinic to arrange a time to drop off your application.

Participating Entheos Audiology Cooperative Clinics	Phone Number	Address
Animas Valley Audiology Associates	970-375-2369	799 E 3rd St., Ste 1 Durango, CO 81301
Columbine Hearing Care	720-689-7989	5808 S Rapp St., Ste 102 Littleton, CO 80120
Flatirons Audiology, Inc.	303-664-9111	320 Empire Rd, Ste 220 Lafayette, CO 80026
Longmont Hearing and Tinnitus Center	303-651-1178	195 S Main St., Ste 8 Longmont, CO 80501
McArthur Audiology, LLC	719-346-5717	366 14th St. Burlington, CO 80807
New Leaf Hearing Clinic, Inc.	303-639-5323	8721 Wadsworth Blvd, Ste C Arvada, CO 80003

For specific questions about the application or eligibility, please call: 720-706-5126 and leave a message or email: colorado@hearingthecall.org.

Intake Form

(Please complete the entire form)

Patient Name: _____ **Date of Birth**: ____/____/____ **Age**: _____
First Last MI

Mailing Address: _____
Street City State Zip

Home Phone #: _____ **Cell Phone #**: _____

Email address: _____ **Occupation**: _____

Number of People in Household (circle one): 1 2 3 4 5 6 7 8 9+ **Sex**: Male | Female

Marital Status (circle one): Single Married Divorced Widowed Domestic Partnership

How would you rate your hearing on a scale of 1-10 with 1 = the worst and 10 = the best? _____

Emergency Contact Name: _____ **Phone #**: _____

Emergency Contact Relationship to Patient: _____

Primary Care Physician: _____ **Phone #**: _____

Referred By: _____

Insurance Type: None | Medicaid | Medicare | Other (please list): _____

Do you have a hearing aid benefit through your insurance? Yes | No **If yes, how much?** $_____

Non-Discrimination Policy: It is the commitment and policy of all participating Entheos Audiology Cooperative Colorado offices and Hearing the Call - Colorado that we do not discriminate against any person on the basis of 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.

****Please read carefully, initial & sign below****

_____ I give permission to all Entheos Audiology Cooperative Colorado offices to release information, verbal and written, contained in my medical record and other related information, to my insurance company, rehab nurse, case manager, attorney, employer, related healthcare providers, assignees and/or beneficiaries and all other related persons. Information without patient identifiers may be used for quality purposes, research or reports to funders.

_____ I acknowledge that I have received and reviewed the Health Insurance Portability & Accountability Act (HIPAA) policy of the individual participating Entheos Audiology Cooperative office where I am receiving my services.

_____ I understand and agree that I am ultimately responsible for the balance of my account for professional services or purchases rendered. I understand that I may request documentation to submit to my insurance or health plan on my own and that participating Entheos Audiology Cooperative offices will not submit this for me.

_____ I have read all the information on this sheet and have completed the above answers, certify this information is true and correct to the best of my knowledge and hereby give participating Entheos Audiology Cooperative offices permission to treat my concerns.

I have read and understood all the above information.

Signature: _____ Date: _____

Demographic Information

Thank you for taking the time to complete the following survey. The information collected will be confidential. 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 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 help us to better provide these services to you and others in our community. Thank you for your time.

Please circle the appropriate responses below.

1. **Do you have any physical and/or diagnosed mental disability?** Yes | No
    a. If yes, please briefly describe: _____
2. **What is your gender identity?** Male | Female | Prefer Not to Answer
3. **What is your age?** 18-24 | 25-34 | 35-44 | 45-55 | 56-65 | 66-79 | 80+
4. **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
5. **Annual Household Income**: less than $10,000 | $10,000-$18,000 | $19,000-$25,000 | $26,000+
6. **What is your primary racial identity?** (Circle all that apply)
    African | African-American | Burmese/Karin | Asian | Caucasian | Hispanic | Middle Eastern | Native American | Not Specified | Other: _____
7. **What is your Primary Language?** English | Spanish | ASL | Burmese | Other: _____
8. **What is your Secondary Language?** (if any): English | Spanish | ASL | Burmese | Other: _____
9. **Do you utilize an interpreter for your medical|wellness visits?** Yes | No | Sometimes
    a. If you answered "yes" or "sometimes," what type of interpreter?
        ASL | Spoken Language: _____
10. **How do you get to your medical/wellness visits?** Car | Friend | Public Transportation | Other: _____
11. **Do you currently wear hearing aids?** Yes | No
    a. If yes, what kind? _____ How old are they? _____

If you selected to not answer any/all of the questions above, please check one box below & initial.

☐ I choose to provide only partial information above.

☐ I choose to **not** provide any information above.

Please initial here: _____

Signature: _____ Date: _____

Eligibility Document Checklist

Patient Name: _____ Date of Birth: _____

Please make copies of the following items that apply to you and your household and **include them with your application packet**.

****PLEASE NOTE:** The items below must be included for **ALL** adults over the age of 18 living in the household. Applications will only be reviewed when all of these documents have been received. Include proof of social security or disability income if a child is under age 18.**

Directions:

- Circle "**Yes**" to indicate that the document listed is included in your packet *OR* circle "**Not Applicable**" for documents that do not apply to you or your household members.
- **Income amount must be listed and proof provided for each applicable document for each household member age 18 and over.**

Item	Applicable?	Income Amount or Account Balance
Intake Form (pages 3 & 4)	Required	N/A
Current Audiogram (performed within last 12 months)	Required	N/A
Copy of Driver's License or State ID	Required	N/A
Copy of Insurance Card (for example: Medicare or Medicaid ID)	Required	N/A
Most Recent Pay Stubs (at least 2)	Yes | Not Applicable	$_____ / month
Proof of Income from Child/Spousal Support	Yes | Not Applicable	$_____ / month
Most Recent Income Tax Returns (last 2 years)	Yes | Not Applicable	$_____ / year
Bank Statements from Checking & Savings Accounts (last 90 days)	Yes | Not Applicable	Balance: $_____
IRA/401K/Investment Income/Stocks/Bonds/Other Assets	Yes | Not Applicable	Total Amount: $_____
Proof of Social Security or Disability Income	Yes | Not Applicable	$_____ / month
Proof of Unemployment Income	Yes | Not Applicable	$_____ / month
Proof of TANF/Financial Assistance Income/Food Stamps	Yes | Not Applicable	$_____ / month
Proof of Extenuating Circumstances and/or Hardships (such as payments on medical bills)	Yes | Not Applicable	N/A

Eligibility & Consent Form

Patient Name: _____ Date of Birth: _____

Hearing the Call - Colorado is available to children *and* adults diagnosed with hearing loss. The following eligibility requirements ***must*** be met to enroll in this project:

- Diagnosed with hearing loss in one or both ears. Current audiogram (hearing test) must be submitted with the application (must be performed within the last 12 months).
- Income not to exceed 250% above 2025 Federal Poverty Guidelines (see guidelines below).
- No more than $10,000 in cash reserves and/or savings.
- 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.
- Must not have an insurance benefit or discount for hearing aids greater than $1,000.
- Ability to complete a total of 10 hours of community service.

2025 Federal Poverty Guidelines	
Household of 1: $39,125.00	Household of 5: $94,125.00
Household of 2: $52,875.00	Household of 6: $107,875.00
Household of 3: $66,625.00	Household of 7: $121,625.00
Household of 4: $80,375.00	Household of 8: $135,375.00

*For families/households with more than 8 people, add $5,500 per additional person.

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 is truthful and accurate to the best of my knowledge.
3) I am not withholding any financial information that was requested as part of this Hearing the Call - Colorado application.
4) I give consent to enroll and receive services through Hearing the Call - Colorado, a partnership between participating Entheos Audiology Cooperative Colorado offices and Hearing the Call, a 501 (c) (3) organization.
5) I give consent to all participating Entheos Audiology Cooperative Colorado offices with Hearing the Call - Colorado to view my personal financial information for the purpose of determining if I meet the eligibility requirements listed above.

_____ _____

Printed Name of Patient or Personal Representative Date

_____ _____

Signature of Patient or Personal Representative Date