Pediatric Hearing Services Application

The Lighthouse is a 501(c)(3) non-profit, non-governmental organization that provides hearing services with dignity and respect to uninsured, low-income people in Georgia.

The hearing aid package for your child is not free. You will have a copayment. Parents or legal guardians may apply once every three (3) years for services for their child (birth – 19 years) based on program funding. The household monthly net income must be within 400% of the federal poverty guideline (page 4).

PLEASE DETACH THE APPLICATION (PAGES 5-12) AND SUBMIT WITH COMPLETE DOCUMENTATION. The estimated time to process your application is 1-2 weeks.

If you are unable or unwilling to provide the requested documentation for you and your child, your child's application will not be approved. If complete documentation is not received within 3 months, your child's application will be considered abandoned, and you will have to begin the application process over.

Please send your application by MAIL OR FAX ONLY:

MAIL: The Lighthouse, 5582 Peachtree Road Chamblee, Georgia 30341
FAX: (770) 406-6558

Hours of operation for The Lighthouse Hearing Department:
Monday – Friday | 9:00 A.M. – 4:00 P.M.
Telephone: 404-325-3630

Application Requirements

In addition to a **completed** application, you must submit supporting documentation to prove your household income, you and your child's identification, your Georgia residency and your child's unexpired hearing test with a Lighthouse provider.

Please submit COPIES ONLY, no original documents.

Need help with the application?
Sound Waves partner Georgia Hands & Voices offers an assistive service, Guide By Your Side, for parents who could use a little help getting the Sound Waves application completed. Contact Scarlett Giles, GA H&V GBYS Program Director at sgiles@doe.k12.ga.us or (470) 991-9187.

Revision Date: February3, 2020

The following MUST be submitted for this application to be considered: Failure to include these documents will delay your child's application and increase the time it takes to get approved. The parent or legal guardian is responsible for providing the required documents listed below.

1. **Proof of Georgia residency for at least 12 consecutive months for 1 parent or legal guardian.**
2. **Birth certificate or valid identification (ID) of the applicant/child.**
3. **Completed Lighthouse-approved Hearing Provider Recommendation (page 8).**
4. **Signed Medical Condition and Clearance (page 8).**
5. **Completed Hearing Program Insurance Affidavit (page 9).**
6. **Copy of a current hearing test, less than 3 months old, with a Lighthouse provider.**
7. **Insurance summary of benefits showing denial or lack of coverage for hearing aid(s) and hearing related devices.**
8. **Copy of your Medicaid pending review letter.**
9. **Completed application with attached supporting documentation.**

SUPPORTING DOCUMENTATION

1) IDENTIFICATION: ALL IDENTIFICATION CARDS MUST BE CURRENT (NOT EXPIRED) AND CLEARLY SHOW YOUR PHOTO. *(Please choose one for parent or legal guardian and one for child/applicant)*

- ❑ Valid state issued driver's license, valid state issued identification card, passport, or consulate identification card (1 parent or legal guardian)
- ❑ Birth certificate, valid state issued driver license, valid state issued identification card, passport, consulate identification card or school identification card (child/applicant)

2) RESIDENCY: *(Please choose one)*

- ❑ Copy of current rental agreement including signature page
- ❑ Copy of most recent Mortgage statement

- ❑ Letter from shelter, transitional home, or nursing home stating that you live at that location (on letterhead and signed by shelter or transitional housing employee)

RESIDENCY: ***(continued)***

- ❑ Copy of a most recent utility bill, including the name of the applicant and service address, from either the applicant or member of household (Utilities only include: gas, water, and electric)

3) INSURANCE:

IF your insurance provides coverage for hearing aids **AND** you partially or fully insured by a high deductible insurance plan* send the following:

- ❑ Copy of your insurance Statement of Coverage, including the deductible

***The Internal Revenue Service (IRS) definition of a "High Deductible Insurance Plan" is defined as any health plan with a deductible of at least $1,350 for an individual or $2,700 for a family.**

- ❑ Copy of your Medicaid pending review letter.

4) INCOME:

Please send **ALL** of the items from this list below that **apply to the parents/legal guardians AND everyone in the household.**

- ❑ Last year's tax return (include all pages)
- ❑ Two (2) current consecutive paycheck stubs for bi-weekly pay; or 4 current consecutive paycheck stubs for weekly pay
- ❑ Current Social Security/Disability Award letter
- ❑ Current Food Stamp award letter from Department of Family and Children Services (DFACS)
- ❑ Letter from shelter (on letterhead and signed by shelter employee)
- ❑ Regular payments from alimony, child support, unemployment, union funds, retirement/pension, or other government programs funds
- ❑ College/university scholarship, grant, fellowship, or assistantship

IMPORTANT: Please be advised that we may request additional supporting documentation such as an official tax transcript. Contact the Internal Revenue Service (IRS) at 1-800-908-9946 to request a 4506-T Form for filing or non-filing transcript.

The applicant's household monthly net income cannot exceed 400% of Federal Poverty Guideline.

2020 Children's Hearing Program
Income Eligibility Chart
(According to the Federal Poverty Guideline)

Household* Size	0-100%	101-150%	151-200%	201-250 %	251-300 %	301-350 %	351-400%
1	$1,063	$1,595	$2,127	$2,658	$3,190	$3,722	$4,253
2	$1,437	$2,155	$2,873	$3,592	$4,310	$5,029	$5,747
3	$1,810	$2,715	$3,620	$ 4,525	$5,430	$6,335	$7,240
4	$2,183	$3,275	$4,367	$5,458	$6,550	$7,641	$8,733
5	$2,557	$3,835	$5,113	$6,392	$7,670	$8,949	$10,227
6	$2,930	$4,395	$5,860	$7,325	$ 8,790	$10,255	$11,720
7	$3,303	$4,955	$6,607	$8,258	$ 9,910	$11,561	$13,213
8	$3,677	$5,515	$7,353	$9,192	$11,030	$12,869	$14,707
9	$4,050	$6,075	$8,100	$10,125	$12,150	$14,175	$16,200
10	$4,423	$6,635	$8,847	$11,058	$13,270	$15,481	$17,693
Add For Each Additional Person	$373	$560	$747	$933	$1,120	$1,306	$1,494

* Household is defined as a social unit comprised of spouses, parents, children, or relatives living in the same dwelling.

Pediatric Hearing Services Application

(PLEASE PRINT CLEARLY WITH A DARK PEN)

Applicant/Child's Information

Last Name: _____ **First Name**: _____ **MI**: ____

Address: _____

City: _____ **State:** Georgia **Zip Code:** _____

County of Residence: _____

Date of Birth: _____/_____ /_____ **Gender:** ☐ Male ☐ Female

Race: ☐ White, not Hispanic or Latino ☐ Black or African American ☐ Asian

☐ American Indian or Alaskan Native ☐ Native Hawaiian or Other Pacific Islander ☐ Other Race

☐ Decline to Specify

Ethnicity: ☐ Hispanic or Latino ☐ Not Hispanic or Latino ☐ Decline to Specify

Primary Parent/Legal Guardian Information

Last Name: _____ **First Name**: _____ **MI**: ____

Address (if different from above): _____

Home Phone: _____ **Mobile Phone:** _____

Email Address: _____

☐ I do not have an email address.

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Legally Separated ☐ Widowed

(You must provide official court documentation if divorced or legally separated)

Are you employed? ☐ Yes ☐ No **Are you a Veteran?** ☐ Yes ☐ No

If you are unemployed, please provide the reason:

☐ Disabled (receive SSI/SSDI) ☐ Retired ☐ Unable ☐ Lost Job ☐ Student ☐ Other

Please select the type of insurance coverage you have:

☐ Medicaid ☐ Medicare ☐ PeachCare ☐ Private ☐ Other ☐ None

Does your insurance plan include hearing aid coverage? Yes No

If yes, are you partially or fully insured by a high deductible insurance plan*? ☐ Yes ☐ No

***The Internal Revenue Service (IRS) definition of a "High Deductible Insurance Plan" is defined as any health plan with a deductible of at least $1,350 for an individual or $2,700 for a family.**

How many years have you been a Georgia resident? _____

How did you hear about The Lighthouse? ☐ The Lighthouse ☐ My Audiologist

☐ Advertising, Marketing, or Social Media ☐ Other Organization ☐ Other Source

Please complete <u>ALL</u> questions above in order for the application to be considered complete.

Privacy Policy

The Lighthouse is committed to protecting the privacy of our applicants. By submitting application to the Lighthouse you consent to the contact forms and personally identifiable information data practices described in this statement.

We collect personally identifiable information voluntarily provided to us, such as name, telephone number, and email address, from all applicants which enables us to communicate with you. We do not sell, rent or lease our customer list to third parties. Unless we receive this signed and dated form from the applicant or applicant parent or legal guardian, personal identifiable information may be shared with Lighthouse partners providing additional applicable support and services.

If you would like to opt out of additional support and services, such as assistance in completing the application, please sign, date and return this form to the Lighthouse. If the completed form is not returned, consent will be implied.

_____ _____

Full Name (printed) Date

_____

Signature

Parent/Legal Guardian Financial Information

In the chart below, **list EVERYONE - including yourself - living at your address**. **Include proof of income for ALL members of the household.**

Name	Age	Relationship	Dependent (Yes or No)	Source(s) of Income	Amount of Monthly Income
		Self	No		$
					$
					$
					$
					$
					$
					$
					$
Total Number of People in Household		Total Number of Dependents in Household		Total Monthly Income (Combined income for all members of household)	$

This section must be completed by the hearing professional who performed the hearing test.
You must include a copy of that current hearing test (audiogram).
The Lighthouse does not pay for hearing tests.

Medical Condition & Clearance

Child's Primary Diagnosis: _____

I recommend the following treatment(s): _____

Are there any medical barriers to treatment? Yes No

If yes, please list: _____

I certify that _____ (**applicant name**) was medically examined on ___/____/___ and may be considered a candidate for hearing aid use.***Must be signed and dated by a licensed physician (M.D.)***

_____ ____/____/____
Signature of M.D. Date

_____ _____
Name of M.D. (Please Print) Name of Physician's Practice

Provider Recommendation for: _____

Print Patient's Name

Business Name: _____

Name and Title of Hearing Professional: _____

Phone Number: _____ Fax Number: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Email Address: _____

Please specify degree of hearing loss: Mild Moderate Moderately Severe Severe Profound

Circle the type of hearing aids recommended:

Right Ear: None RIC/BTE ITE BI CROS

Left Ear: None RIC/BTE ITE BI CROS

Is this facility a Lighthouse Provider? **Yes** **No**

If no, patient needs to follow instructions on Page 10.

If no, are you interested in becoming a Lighthouse Provider? **Yes** **No**

Contact us at 404.325.3630 or visit www.LighthouseGeorgia.org for more information.

Insurance Affidavit

This insurance affidavit must be completed by the hearing professional who performed the hearing test.

I, _____ (full printed name), declare under penalty of perjury that the following is true and correct to the best of my knowledge, information and belief.

Name of Practice: _____

Address: _____

Signature of Provider: _____

I confirm that the following has been verified on the patient listed below:

Name of Patient: _____

_____The patient does not carry medical insurance

_____The patient carries medical insurance, but Hearing services are not covered in the policy

A copy of this affidavit is being filed with The Lighthouse in the designated Hearing Program electronic patient filing system. Patient information will be kept on record for a minimum of three years. The Lighthouse accepts the affidavit in good faith.

Provider Print Name: _____

Provider Signature: _____

Date: _____

The Lighthouse Approved Hearing Providers

There are certain hearing providers who work with The Lighthouse hearing program. This means they accept payment from The Lighthouse on your behalf. It also means they abide by the guidelines of The Lighthouse program and agree to provide the services included in your hearing aid package.

For this reason, you **MUST** be a patient of a Lighthouse-approved hearing provider. A list can be found on our website, www.LighthouseGeorgia.org or by calling 404-325-3630.

What does this mean if you already have a hearing test? Can you use it?

Maybe. All hearing tests must be current. According to Georgia law, that means it must be 6 months old or less. Furthermore, if your hearing test does not come from a Lighthouse-approved provider, our Lighthouse providers *may* require you to get a new test from them before you can proceed to be their patient. If you have a current test you wish to use, you will need to ask your new Lighthouse provider if he/she will accept it.

How do you find a Lighthouse-approved hearing provider?

You can find a current list of providers at www.LighthouseGeorgia.org, or you can call the Lighthouse Foundation at 404-325-3630 to request a list.

1. Choose a Lighthouse Provider from the provided list.

2. Call the Provider you have chosen. Tell them that you are applying to The Lighthouse for hearing aid assistance and you need a Lighthouse-approved provider.

   * If you **have** a hearing test that is **less than 3 months old**, ask them if they will accept it.
   * If you **do not have** a hearing test, tell them you need one.

3. Ask the Provider if they are willing to accept you as a new patient. If the provider agrees to accept you as a patient, you will see this provider for your Lighthouse-approved hearing appointments.

   * If the provider is not willing to accept you as a new patient, choose another provider from the list who is in your area and repeat the steps above.

Write name and address of your Lighthouse-approved hearing provider here:

_____

REQUIRED

Lighthouse Statement Please read and sign.

"I fully understand Lighthouse services are limited to residents unable to pay for, or receive from other sources, this assistance. In consideration of these services, I release and discharge all persons rendering such services from any claims I may have arising from the services rendered. I am aware that the Lighthouse will not pay for any hearing aids billed to me prior to approval of this application. I also understand that my application will be reviewed by a Lighthouse Provider, and/or the Lighthouse staff. ALL INFORMATION ON AND ATTACHED TO THIS APPLICATION IS TRUE AND CORRECT TO THE BEST OF MY KNOWLEDGE."

➡ _____ _____

Signature of Applicant (or parent if applicant is a child) Date

_____ _____

Witness (if applicant signs with an "X") Date

REQUIRED

HIPAA Agreement

I understand that the Federal Privacy Rule ("HIPAA") does not protect the privacy of information if re-disclosed, and therefore request that all information obtained by this person or agency be held strictly confidential and not be further released by the recipient. I further understand that my eligibility for Lighthouse services is not conditioned upon my provision of this authorization. I intend for this document to be a valid authorization conforming to all requirements of the Privacy Rule and understand that my authorization will remain in effect for one year.

➡ _____ _____

Signature of Applicant (or parent if applicant is a child) Date

Complete this portion <u>only</u> if you would like to give us permission to speak with someone else on your behalf regarding your/your child's services.

Name: _____ Phone: _____

Relationship to Applicant/Child: _____

Once completed, send your application and copies of all required documents to us by mail, or FAX. If you have any questions, please call us at 404-325-3630 and listen to menu prompt.

"By submitting this application, I agree to be bound by The Lighthouse's terms, conditions, and decisions regarding approval or denial. I understand that I am responsible for submitting in a timely fashion all supporting materials and that, if said materials are not received within ninety (90) calendar days of application submission, my application will be considered abandoned, necessitating the submission of a new application. I also agree to allow the use of my and/or my child's likeness (photograph) in any form of future program marketing and understand that, if I do not wish to consent to the use of said likeness, I must submit in writing a signed statement to that effect to be included in my application file."