Johnson Audiology Hearing Foundation

PROVIDING HEARING HEALTH CARE TO THOSE IN NEED

ARE YOU READY TO BEGIN THE JOURNEY TO BETTER HEARING BUT FINANCIAL NEED IS BLOCKING YOUR PATH?

WE WANT TO HELP!

Read on for additional information about the Johnson Audiology Hearing Foundation and to apply for assistance.

Please note: The application form and documentation must be completed in its entirety.
The completed application packet will be reviewed by the Foundation's review committee for eligibility on a quarterly basis, and you will be contacted if your application has been accepted . The Foundation seeks to make hearing aids available to as many people as possible, but resources are not unlimited.
Please be aware that the hearing aid package is not free. Recipients of funding through JAHF will have a modest co-payment.

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Hearing Services Application Packet

The Johnson Audiology Hearing Foundation (JAHF, or the Foundation) is a 501(c)(3) non-profit, non-governmental organization that provides hearing services and technology with dignity and respect to low-income people in the regions where Johnson Audiology has offices.

The hearing aid package is not free. You will have a modest co-payment. Individuals ages 20 years and older may apply once every three (3) years for consideration for services based on availability of JAHF program funding. The household monthly net income cannot exceed 200% of the federal poverty guidelines (see chart on page 4).

Your completed application packet will be assessed by the Foundation's review committee for eligibility, and you will be contacted with the assessment results. The Foundation seeks to make hearing aids available to as many people as possible, but **please be aware that resources are not unlimited**.

PLEASE DETACH THE APPLICATION (PAGES 2-11) AND SUBMIT WITH COMPLETE DOCUMENTATION.
The estimated time to process your application is 4-6 weeks.

If you are unable or unwilling to provide the requested documentation, your application will not be approved. If complete documentation is not received within 3 months of initial submission, your application will be considered abandoned, and you will have to begin the application process again. You must wait 6 months to reapply.

Please send your application by MAIL OR FAX ONLY:

MAIL: JOHNSON AUDIOLOGY HEARING FOUNDATION
5617 Highway 153
Suite 203
Hixson, TN 37343

FAX: 1+423.933.3479
Send to: Johnson Audiology Hearing Foundation, Attn: Jan Hollingsworth
You must dial a 1 + the number even when sending from the 423 area code.

Application Requirements
In addition to a **completed** application, you **must submit supporting documentation** to prove your household income, identification, residency, etc. A complete checklist of required documentation follows.
Please submit COPIES ONLY, no original documents.

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I wish to apply with the Johnson Audiology Hearing Foundation for the following needs:

☐ **I need hearing aids.**

☐ **I already have hearing aids and need help with them. If this is the case, please fill in the information below.**

Brand name/manufacturer of the hearing aids:

- ☐ Widex
- ☐ Resound
- ☐ Oticon
- ☐ Siemens
- ☐ Signia
- ☐ Starkey
- ☐ Beltone
- ☐ Miracle Ear
- ☐ Audibel
- ☐ Bernafon
- ☐ Listen Lively
- ☐ Other: (Please specify.) _____

Style of hearing aids:

- ☐ Behind the ear (BTE)/Receiver in the Canal (RIC)
- ☐ In the ear custom styles

Right hearing aid serial number: _____

Left hearing aid serial number: _____

Where did you get your hearing aids?

- ☐ Gifted to me
- ☐ I purchased at a brick and mortar location
- ☐ I purchased online
- ☐ Other: (Please specify.) _____

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Supporting Documentation Checklist

The items outlined below MUST be submitted for this application to be considered: Failure to include these documents will delay your application and increase the time it takes the JAHF review committee to contact you with word on whether you have been selected as a recipient of hearing aid technology and/or hearing health care services. Applicants are individually responsible for providing the required documents listed below.

Please submit COPIES ONLY, no original documents.

SUPPORTING DOCUMENTATION

1. **IDENTIFICATION: ALL IDENTIFICATION CARDS MUST BE CURRENT (NOT EXPIRED) AND CLEARLY SHOW YOUR PHOTO.** *(Please choose one.)*

- ❑ Valid state issued driver's license
- ❑ Valid state issue identification card
- ❑ Passport
- ❑ School identification card
- ❑ Consulate identification card

2. **RESIDENCY:** *(Please choose one.)*

- ❑ Current rental agreement, including signature page
- ❑ Most recent mortgage statement
- ❑ Letter from shelter, transitional home or nursing home stating that you live at that location (must be on letterhead and signed by shelter or transitional housing employee)
- ❑ 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 ARE PARTIALLY OR FULL INSURED BY A HIGH DEDUCTIBLE INSURANCE PLAN*, SEND THE FOLLOWING:**

- ❑ 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 and $2,700 for a family.

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4. **<u>INCOME</u>: PLEASE SEND <u>ALL</u> OF THE ITEMS FROM THE LIST BELOW THAT APPLY TO <u>YOU AND EVERYONE IN THE HOUSEHOLD</u>.**

- ❑ 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 nursing home (on letterhead and signed by nursing home employee
- ❑ Letter from shelter (on letterhead and signed by shelter employee)
- ❑ Regular payments from alimony, child support, unemployment, union funds, retirement/pension accounts(s), or other government program 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.

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2024 Income Eligibility Chart

(According to the Federal Poverty Guideline)

To be considered as a recipient of the Johnson Audiology Hearing Foundation, the applicant's household monthly net income cannot exceed 200% of the Federal Poverty Guideline.

Household* Size	0-100%	151-200%
1	$1,255	$2,510
2	$1,703	$3,406
3	$2,152	$4,304
4	$2,600	$5,200
5	$3,048	$6,096
6	$3,469	$6,992
7	$3,945	$7,890
8	$4,393	$8,786
9	$4,841	$9,682
10	$5,290	$10,580

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

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Please print clearly
with a dark pen.

Johnson Audiology
Hearing Foundation
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Application

Last name: _____ **First name:** _____ **MI:** _____

Address: _____

City: _____ **State:** _____ **Zip code:** _____ **County:** _____

Home phone: _____ **Mobile phone:** _____

Email address: _____ ☐ **I do not have an email address.**

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

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** ☐ **Child** ☐ **Other**

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**

Please select the type of health insurance coverage you have:

☐ **Medicaid** ☐ **Medicare** ☐ **State Administered Medicare Plan** ☐ **Private**

☐ **Other:** _____ ☐ **None** **Please list all policies below.**

Plan/policy number: _____ **Group number:** _____

Plan/policy number: _____ **Group number:** _____

Plan/policy number: _____ **Group number:** _____

Have you ever had a hearing test? ☐ **Yes** ☐ **No**

If so and you have access to it, please include a copy with this application packet.

Have you worn hearing aids in the past but do not currently? ☐ **Yes** ☐ **No**

My hearing loss is ☐ **Mild** ☐ **Moderate** ☐ **Profound** **(A mild or moderate loss will not disqualify you from consideration.)**

I have tinnitus (ringing in the ears) ☐ **Yes** ☐ **No**

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Does your insurance plan include hearing aid coverage? ☐ **Yes** ☐ **No** ☐ **I don't know**

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 and $2,700 for a family.

How did you hearing about the Johnson Audiology Hearing Foundation:

_____

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Financial Information

In the chart below, list everyone — including yourself — living at your address. Include proof of income for ALL members of the household. Attach additional household members on a separate sheet or list on the back of this page.

Name	Age	Relationship	Dependent Yes or No	Source(s) of Income	Amount of Monthly Income
					$
					$
					$
					$
					$
					$
					$
Total Number of People in Household		Total Number of Dependents in Household		Total Monthly Net Income (total all monthly incomes above)	$

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Authorization to Request Records

If you have had a hearing diagnostic test in the last 6 months by an audiologist or have been seen by an Ear, Nose and Throat doctor, please sign below to give us permission to request these records before your first appointment with the Johnson Audiology Hearing Foundation. Thank you.

Last name: _____ First name:_____ M.I.____

Date of birth _____/_____/_____

I hereby give the Johnson Audiology Hearing Foundation permission to contact and obtain my medical records from:

Provider name: _____

Phone number: _____ Fax number: _____

Address:_____

City: _____ State:_____ Zip code:_____

Signature of patient: _____Today's date:_____

Signature of parent or guardian if patient is a minor: _____

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Required

Johnson Audiology Hearing Foundation Statement Please read and sign.

"I fully understand that Johnson Audiology Hearing Foundation services are limited to those 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 award that the Johnson Audiology Hearing Foundation 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 Johnson Audiology Hearing Foundation/Johnson Audiology staff member. **All information on and attached to this application is true and correct to the best of my knowledge."**

Signature of applicant (person applying for services):

_____**Today's date:**_____

Witness if applicant signs with an X:

_____**Today's date:**_____

Required

HIPPA Agreement

"I understand that the Federal Privacy Rule ("HIPPA") 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 Johnson Audiology Hearing Foundation services is not conditioned upon my provision of this authorization. I intend for this document to be 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 (person applying for services):

_____**Today's date:**_____

Complete this box only if you would like to give us permission to speak with someone else on your behalf regarding your services.

Name:_____**Phone number:**_____

Relationship of applicant: _____

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Once completed, send your application and copies of all required documents to the Johnson Audiology Hearing Foundation by mail or fax.

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Send to: Johnson Audiology Hearing Foundation, Attn: Jan Hollingsworth
You must dial a 1 + the number even when sending from the 423 area code.

If you have any questions, please contact Jan Hollingsworth at the Foundation at 423.713.5266.

"By submitting this application, I agree to be bound by The Johnson Audiology Hearing Foundation'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."