



## Pediatric Hearing Services Application & Info Packet

### NEED HELP WITH THE APPLICATION?

GCCN partner Georgia Hands & Voices offers an assistive service, *Guide by Your Side*, for parents who could use a little help getting the application completed. Contact Scarlett Giles, GA H&V GBYS Program Director at [sgiles@doe.k12.ga.us](mailto:sgiles@doe.k12.ga.us) or 470-991-9187.

The Georgia Charitable Care Network 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 send your application by MAIL OR FAX ONLY:**

**MAIL: The Georgia Charitable Care Network, PO Box 133224, Atlanta GA 30333**

**FAX: 866-329-8147**

**Hours of operation for the Hearing Aid Dispatch Program:**

**Monday – Friday | 9:00 A.M. – 4:00 P.M.**

**Telephone: 888-551-1231**

### Application Requirements

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

**Please submit COPIES ONLY, no original documents.**

Revision Date: July 5, 2022

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

1. Completed GCCN-approved Hearing Provider Recommendation (page 8).
2. Signed Medical Clearance or Medical Waiver (page 8).
3. Copy of a current hearing test, less than 3 months old, with a GCCN provider.
4. Insurance summary of benefits showing denial or lack of coverage for hearing aid(s) and related (page 9).

## SUPPORTING DOCUMENTATION

1) **IDENTIFICATION: ALL IDENTIFICATION CARDS MUST BE CURRENT (NOT EXPIRED) AND CLEARLY SHOW THE PARENT/LEGAL GUARDIAN'S PHOTO. (Please choose one for parents or legal guardian and one for child/applicant)**

- Valid state issued driver's license
- Valid state issued identification card
- Passport
- School identification card
- Consulate identification card (1 parent or legal guardian)
- Birth certificate

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

- Copy of most recent Mortgage statement
- Letter from shelter, transitional home stating that you live at that location (on letterhead and signed by shelter or transitional housing employee)
- Valid ID showing current address

#### 4) INCOME:

Please send documents from the list below that **apply to the parents/legal guardians AND everyone in the household.**

- Last year's tax return (1040)
- 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 parent/legal guardian's monthly household net income cannot exceed 400% of the Federal Poverty Guideline.

**2022 Income Eligibility Chart  
(According to the Federal Poverty Guideline)**

Household* Size	400%
1	\$ 4,253
2	\$ 6,103
3	\$ 7,677
4	\$ 9,250
5	\$10,823
6	\$12,397
7	\$13,970
8	\$15,543
9	\$17,117
10	\$18,690

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



**Pfediatic Hearing Services Application**  
*(PLEASE PRINT CLEARLY WITH A DARK PEN)*

**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:** \_\_\_\_\_

**City:** \_\_\_\_\_ **State:** Georgia **Zip Code:** \_\_\_\_\_

**County of Residence:** \_\_\_\_\_

**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

How many years have you been a Georgia resident? \_\_\_\_\_

How did you hear about the Georgia Charitable Care Network?

Georgia Charitable Care Network  My Audiologist  Advertising, Marketing, or Social Media  
 Other Organization  Other Source \_\_\_\_\_

***Please complete ALL questions above in order for the application to be considered complete.***

## 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.** Attach additional household members on 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
		Self	No		\$
					\$
					\$
					\$
					\$
					\$
					\$
					\$
					\$
					\$
<i>Total Number of People in Household</i>		<i>Total Number of Dependents in Household</i>		<i>Total Monthly Net Income (Combined income for all members of household)</i>	\$

Provider Recommendation for: \_\_\_\_\_

Print Patient's Name

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 Georgia Charitable Care Network does not pay for hearing tests.**

### Medical Waiver

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.

\_\_\_\_\_  
Name of M.D. (Please Print)

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 and if an ear mold is required:

Right Ear:	None	RIC/BTE	ITE	BI CROS	CROS	Ear Mold: <input type="checkbox"/> Yes <input type="checkbox"/> No
Left Ear:	None	RIC/BTE	ITE	BI CROS	CROS	Ear Mold: <input type="checkbox"/> Yes <input type="checkbox"/> No

Is this facility a GCCN Provider?  Yes  No

*If no, patient needs to follow instructions on Page 9.*

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

Contact us at 678-389-3333 or visit [www.charitablecarenetwork.org](http://www.charitablecarenetwork.org) for more information.

### **Insurance Affidavit (Please PRINT)**

This insurance affidavit must be completed by the hearing professional who performs 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: \_\_\_\_\_

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

Name of Patient: \_\_\_\_\_

- The patient is not covered by medical insurance.
- The patient is covered by medical insurance, but hearing services are not covered in the policy.
- Insurance summary of benefits.

A copy of this affidavit is being filed with GCCN in the designated hearing aid program filing system. Patient information will be kept on record for a minimum of three years. GCCN accepts the affidavit in good faith.

\_\_\_\_\_  
Signature of Provider

\_\_\_\_/\_\_\_\_/\_\_\_\_  
Date

**Georgia Charitable Care Network Statement** Please read and sign.

**REQUIRED**

“I fully understand that the services of the Georgia Charitable Care Network 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 Georgia Charitable Care Network 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 GCCN Provider, and/or The Georgia Charitable Care Network staff. ALL INFORMATION ON AND ATTACHED TO THIS APPLICATION IS TRUE AND CORRECT TO THE BEST OF MY KNOWLEDGE.”



\_\_\_\_\_  
**Signature of Parent/Legal Guardian**

\_\_\_\_\_  
**Date**

\_\_\_\_\_  
**Witness** (if applicant signs with an “X”)

\_\_\_\_\_  
**Date**

**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 GCCN 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.

**REQUIRED**



\_\_\_\_\_  
**Signature of Applicant** (person applying for services)

\_\_\_\_\_  
**Date**

**REQUIRED**

By submitting this application, I agree to be bound by the Georgia Charitable Care Network’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.



\_\_\_\_\_  
**Signature of Parent/Legal Guardian**

\_\_\_\_\_  
**Date**

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

Name: \_\_\_\_\_ Phone: \_\_\_\_\_

Relationship to Applicant: \_\_\_\_\_

**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 888-551-1231.**

# Georgia Charitable Care Network Approved Hearing Providers

There are certain hearing providers who work with the Georgia Charitable Care Network (GCCN) hearing aid dispatch program. This means they accept payment from the Georgia Charitable Care Network on your behalf. It also means they abide by the guidelines of the Georgia Charitable Care Network program and agree to provide the services included in your hearing aid package.

For this reason, you **MUST** be a patient of a GCCN-approved hearing provider. A list can be found on our website, [www.charitablecarenetwork.org](http://www.charitablecarenetwork.org) by calling 888-551-1231.

## ***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 GCCN-approved provider, our GCCN 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 GCCN provider if he/she will accept it.

## ***How do you find a GCCN-approved hearing provider?***

You can find a current list of providers at [www.charitablecarenetwork.org](http://www.charitablecarenetwork.org), or you can call the Georgia Charitable Care Network at 888-551-1231 to request a list.

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## **Once you have the list of providers, please follow these three steps:**

1. Choose a GCCN Provider from the provided list.
2. Call the Provider you have chosen. Tell them that you are applying to The Georgia Charitable Care Network for hearing aid assistance and you need a GCCN-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 GCCN-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.

**Print the name and address of your GCCN-approved hearing provider who you have called to confirm:**