Dear Applicant,

Thank you for your interest in Hearing the Call Central Texas for hearing healthcare assistance. We are so glad that you have learned about our non-profit project program, and we are excited to begin serving you for all of your future hearing healthcare needs.

The non-profit project program is a partnership between Hearing the Call Central Texas, a 501(c)3 nonprofit organization, and private practice audiologists established to meet the hearing needs of low-income individuals. The partnership allows for hearing services to be offered at a reduced fee based on the applicant's household size and income. Our goal is to make quality hearing care more affordable and accessible to those in need. This assistance comes through donations from audiologists and other donors from our state and across the U.S.A. We ask all participants to pay this generosity forward through volunteer hours at their charity of choice.

To qualify for our program, you must meet certain financial criteria based on Federal Poverty Guidelines. Please take a few moments to review this packet, which includes documentation requirements for the application. Simply complete the following forms and submit your supporting documents.

- Intake Form
- Eligibility & Consent Form
- Demographic Information
- Eligibility Document Checklist
- Video & Photography Consent Form
- HIPAA

Your privacy is of utmost importance to us and these documents are only viewed for eligibility determination. Once the documents have been reviewed and accepted by our team you will receive notification and further instructions. If you have any questions about this process or about the required paperwork, please do not hesitate to ask us.

Intake Form

Applicant Name: _____ Date of Birth: ____/____/____
MM DD YYYY

Referred By: _____

Contact Information:

Mailing Address: _____

Home Phone: _____ Cell Phone: _____ Work Phone: _____

Email Address: _____

Personal Information:

SSN: _____ Gender Identity: M ☐ F ☐ Other

Occupation: _____ Employer: _____ N/A

How many people live in your Household?: _____ Marital Status: _____

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

1 - - - 2 - - - 3 - - - 4 - - - 5 - - - 6 - - - 7 - - - 8 - - - 9 - - - 10 _____

Emergency Contact:

Name: _____ Relationship: _____ Phone #: _____

Primary Care Physician: _____ City: _____ Phone: _____

Insurance Type:

- ☐ None
- ☐ Medicaid
- ☐ Medicare
- ☐ Other

Non-Discrimination Policy: It is the commitment and policy of Hearing the Call and its partners that we do not discriminate against any person based on 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.

Eligibility & Consent Form

(Revised 5/27/2026)

The following eligibility requirements must be met to enroll in this non-profit project program:

1. Diagnosed with hearing loss in one or both ears.
2. No private health insurance benefit for hearing aids.
3. Complete a total of 10 hours of community service or acts of kindness.
4. No more than $10,000 in cash reserves and/or savings.
5. No more than $50,000 in accessible finances in retirement and/or investments.
6. Household Income not to exceed 250% above the federal poverty level.

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. Depending on household size, the applicant's total household income must be under:

Household of 1:	$33,975.00	**Household of 5:**	$81,175.00
Household of 2:	$45,775.00	**Household of 6:**	$92,975.00
Household of 3:	$57,575.00	**Household of 7:**	$104,775.00
Household of 4:	$69,375.00	**Household of 8:**	$116,575.00

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 for program eligibility was truthful and accurate to the best of my knowledge.
3. I am not withholding any requested financial information that was requested as part of the program application.
4. I give consent to enroll and receive services from the participating partner of Hearing the Call.
5. I give consent to allow the participating partner of Hearing the Call and all individuals associated with Hearing the Call to view my personal financial information for the purpose of determining if I meet the financial eligibility requirements.

Applicant/Representative Name: _____

Applicant/Representative (Signature): _____ Date: _____

Demographic Information

Thank you for taking the time to complete the following survey. The information collected will be confidential (see our HIPAA disclosure). 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 of 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 in helping us to better provide these services to you and others in our community. Please circle the appropriate responses below.

Do you have any physical and/or diagnosed mental disability? Yes ☐ or No ☐

If yes, please briefly describe: _____

What is your gender identity? Male ☐ Female ☐ Other

What is your age? 18-24 ☐ 25-34 ☐ 35 – 44 ☐ 45 – 55 ☐ 56 – 65 ☐ 66 – 79 ☐ Over 80 ☐

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 ☐

Annual Household Income less than $10,000 ☐ $10,000 to $18,000 ☐ $19,000-$25,000 ☐ over $26,000 ☐

What is your Primary language: English ☐ Spanish ☐ ASL ☐ Burmese ☐ Other: _____

What is your Secondary Language (if any): English ☐ Spanish ☐ ASL ☐ Burmese ☐ Other: _____

Do you utilize an interpreter for your medical/wellness visits? Yes ☐ No ☐ Sometimes ☐

If you answered yes or sometimes, what type of interpreter? ASL ☐ or Spoken Language: _____

How do you get to your medical/wellness visits? Car ☐ Friend ☐ Public Transportation ☐ Other: _____

What is your primary racial identity?

African ☐ African-American ☐ Burmese/Karin ☐ Asian ☐ Caucasian ☐ Hispanic ☐ Middle Eastern ☐ Native American ☐

Other Race Not Listed: _____

☐ I choose to provide only partial information above.

☐ I choose not to provide any information above.

INITIAL_____

Eligibility Document Checklist

Applicant Name: _____ **DOB:** _____

Please make copies of the following items that are applicable to you and your household and return them to our office within 90-days. Please include documents for all adults over age 18 living in the household. Include only proof of social security/disability income if a child is under age 18.

ITEM	NOTES
Copy of Driver's License or State ID	☐ Yes ❑ No
Medicaid ID/Insurance information	☐ Yes ❑ Not Applicable
Most Recent Paystubs (need at least 2)	☐ Yes ❑ Not Applicable
Proof of Income from Child Support/Spousal Support	☐ Yes ❑ Not Applicable
Most Recent Income Tax Return (last two years)	☐ Yes ❑ Not Applicable
Bank Statement (from the last 60 days)	☐ Yes ❑ Not Applicable
IRA/Investment Income/401K/Stocks/Bonds or other assets	☐ Yes ❑ Not Applicable
Proof of Residence (utility bill, lease, or other)	☐ Yes ❑ Not Applicable
Proof of Social Security or Disability Income	☐ Yes ❑ Not Applicable
Proof of Unemployment Income	☐ Yes ❑ Not Applicable
Proof of Financial Assistance Income, or Food Stamps	☐ Yes ❑ Not Applicable
Proof of Extenuating Circumstance and/or Hardships (list below)	☐ Yes ❑ Not Applicable

_____

_____

_____

_____

Video & Photography Consent And Release Form

I, _____, hereby give permission to Hearing the Call and its agents to use and reproduce my image, likeness, voice, and name (collectively, "Image") and to authorize others to use my Image in any manner in any and all media now known or hereafter discovered or developed, in perpetuity, throughout the universe including but not limited to reproducing my Image in print publications, web sites, and audio-visual broadcasts. I understand and agree that Hearing the Call will own all rights in my Image, including all rights under copyright.

I expressly waive any right I might have of prior approval over how and where my Image is used and compensation and all rights of privacy and under any Federal or State statutes that may apply. I forever release and discharge Hearing the Call, and its respective officers, employees, agents and other persons acting within the scope of their authority from any and all claims or causes of action, now known or later discovered, relating to or arising out of use of my Image, including but not limited to claims for invasion of privacy or misappropriation, right of publicity and defamation arising out of the use and exploitation of my Image.

I represent that I am over the age of 18-years, that I have read this permission, am fully familiar with its contents and meaning, and have been given the opportunity to consult counsel of my choosing prior to signing this Permission and Release.

Applicant/Representative Name (printed): _____

Applicant/Representative Signature: _____ Date: _____

-HIPAA-

Authorization for the Use or Disclosure of Protected Health Information (PHI)

For the purposes of diagnosing or providing hearing care and treatment for me, I consent to the use or disclosure of my Protected Health Information (including Audiograms) to the following (hereinafter, Providers):

- ENTHEOS AUDIOLOGY COOPERATIVE, INC
- HEARING THE CALL, INC
- _____
- _____
- _____
- _____

I understand that diagnosis or treatment for me by the Providers may be conditioned upon my consent as evidenced by my signature on this document.

My Protected Health Information (PHI) means health information, including my demographic information, collected from me and created or received by my physician, another healthcare provider, a health plan, my employer or a healthcare clearinghouse. This PHI relates to my past, present or future physical or mental health or condition and identifies me, or there is reasonable basis to believe the information may identify me.

I understand I have the right to request a restriction as to how my PHI is used or disclosed to carry out hearing care and treatment. Providers are not required to agree to the restrictions that I may request. However, if Providers agree to a restriction that I request in writing, the restriction is binding to Providers. I have the right to revoke this consent, in writing, at any time, except to the extent that Providers have taken action in reliance on this consent.

I consent to Providers' use or disclosure of my PHI for purposes of delivering relevant product and/or technology marketing communication to me. I acknowledge that Providers may receive financial remuneration from the manufacturer in connection with such communication.

I acknowledge that I have been given the opportunity to review Providers' Notice of Privacy Practices and that a copy is available both for review and my own records should I so inquire. I understand that should I refuse to sign this acknowledgment of receipt; Providers are not obliged to treat me.

_____ _____

Signature of Patient or Personal Representative Date

_____ _____

Print Name of Patient or Personal Representative Description of Personal Representative's Authority