NEW PATIENT APPLICATION

Dear Patient,

We're so glad that you have learned about our new program, and we are excited to begin serving you.

Pacific Hearing Connection, Inc. is a 501(c)(3) nonprofit organization established to meet the hearing needs for low income children and adults in Northern California. We provide reduced fee hearing services on a sliding scale system based on household size and income, making hearing care more affordable and accessible for our patients who could otherwise not afford it.

To qualify for our program, you must meet certain financial criteria based on Federal Poverty Guidelines and be able to complete volunteer service hours. Please review this packet and submit the required documentation within the next 90 days. If you have any questions about this process, please do not hesitate to contact us. You can reach us by phone at **650-434-2181** or by email at **contact@pacifichearingconnection.org**.

Sincerely,

Jane H. Baxter, Au.D. and Deborah Wilson Clark, Au.D. – Founders
Pacific Hearing Connection

PACIFIC Hearing CONNECTION

PATIENT INTAKE FORM

Patient Name: _____ **D.O.B.** _____/_____/_____
First Last MI M D Y

Mailing Address: _____
Street City State Zip

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

Work Phone #: _____ **Email:** _____

Gender: □ M □ F □ NB

Household Size (please circle): 1 2 3 4 5 6 7 8 9+

Marital Status: □ Married □ Single □ Divorced □ Widowed □ Domestic Partnership

Insurance Type: □ None □ Medi-Cal □ Other: _____

Referred by: _____

Emergency Contact: _____

Phone #: _____ **Relationship to Patient:** _____

Non-Discrimination Policy: It is the commitment and policy of Pacific Hearing Connection, Inc. that it does 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.

Initials: _____ I acknowledge that Pacific Hearing Connection's Notice of Privacy Practices is provided in the reception area. I acknowledge a paper copy is available to me upon request and I have been informed that I will be offered a copy of any amended Notice of Privacy Practices at each appointment.

Initials: _____ I understand and agree that I am ultimately responsible for the balance of my account for professional services or purchases rendered. I may request clarification regarding my balance and documentation to submit to my insurance or health plan. I understand that Pacific Hearing Connection will not submit this for me.

Initials: _____ 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 Pacific Hearing Connection permission to treat my concerns.

Signature of Patient: _____ **Date:** _____
A copy of this signature is as valid as the original.

Signature of Parent or Guardian if patient is a minor: _____

DEMOGRAPHIC INFORMATION

Thank you for taking the time to complete the following survey. The information collected will be confidential and will not be used in determining eligibility for our services. By completing our survey, you help us in identifying disparities in our community so that we may make informed improvements and provide better service. Thank you for your time. Please mark the appropriate responses below:

Do you have any physical or cognitive impairment, and/or diagnosed mental illness? □ Yes □ No

If yes, please briefly describe: _____

What is your gender identity? □ Male □ Female □ Non-binary

What is your age? □ Under 18 □ 18-24 □ 25-34 □ 35-44 □ 45-54 □ 55-64 □ 65-80 □ 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 $12,000 □ $12,000 to $20,000 □ $20,000 to $35,000 □ $35,000 to $50,000
□ Over $50,000

What is your primary language? □ English □ Spanish □ ASL □ Other: _____

What is your secondary language? □ English □ Spanish □ ASL □ Other: _____

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

If yes or sometimes, what type of interpreter? □ ASL □ Spoken Language: _____

How do you get to your medical visits? □ Car □ Public Transportation □ Other: _____

What is your primary racial identity? (Mark all that apply) □ Asian □ Black □ Latino □ Middle Eastern

□ Native American □ Pacific Islander □ White □ Not Specified □ Other Race Not Listed: _____

Initials: _____

PACIFIC Hearing CONNECTION

AUTHORIZATION TO REQUEST RECORDS

If you have had a recent hearing evaluation or have seen an Ear, Nose, Throat doctor, please sign below to give us permission to request these records before your first appointment. Thank you.

Patient Name: _____ **D.O.B.** _____/_____/_____
First Last MI M D Y

I hereby give Pacific Hearing Connection, Inc. permission to contact and obtain my medical records from:

Provider Name: _____

Phone #: _____ **Fax #:** _____

Address: _____
Street City State Zip

Signature of Patient: _____ **Date:** _____
A copy of this signature is as valid as the original.

Signature of Parent or Guardian if patient is a minor: _____

Pacific Hearing Connection
496 1st Street, Los Altos, CA 94022
650-434-2181

contact@pacifichearingconnection.org

www.pacifichearingconnection.org

PACIFIC Hearing CONNECTION

AUTHORIZATION TO USE AND DISCLOSURE OF HEALTH INFORMATION

Patient Name: _____ **D.O.B.** _____/_____/_____
First Last MI M D Y

I request and authorize Pacific Hearing Connection to disclose my protected health information as described below. I understand that if the person/organization authorized to receive and use the information is not a health plan or health care provider, the disclosed information may no longer be protected by federal privacy regulations.

My protected health information (for example, hearing healthcare records) may be disclosed to the following:

1. _____
2. _____
3. _____

I understand that I have the right to request restrictions as to how my protected health information may be used or disclosed by Pacific Hearing Connection.

I understand that this authorization is in effect until written notice of revocation is received. I may revoke this authorization at any time by notifying Pacific Hearing Connection.

I authorize Pacific Hearing Connection's use and disclosure of my protected health information as set forth above. I understand that this authorization is voluntary and that Pacific Hearing Connection cannot condition my treatment, services, etc. on the signing of this authorization. I understand that if I am signing on behalf of a minor child, this authorization will expire upon the child reaching the age of 18, unless there is proof of legal guardianship.

This authorization will expire (must choose one):

□ Upon written notice by me
□ Other (insert date or event): _____

Signature of Patient: _____ **Date:** _____
A copy of this signature is as valid as the original.

Signature of Parent or Guardian if patient is a minor: _____

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ELIGIBILITY DOCUMENTS

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

- ☐ Copy of driver's license or state ID and Medi-Cal ID
- ☐ Most recent paystubs (need at least 2)
- ☐ Most recent income tax return (last year or two years)
- ☐ Bank statement (last 60 days)
- ☐ IRA/investment income/401K/stocks/bonds or other assets
- ☐ Proof of residence (utility bill, lease, or other)
- ☐ Proof of Social Security or disability income
- ☐ Proof of unemployment income
- ☐ Proof of TANF or other financial assistance income or food stamps
- ☐ Letter of referral/denial of services (Catholic Charities, Matthew 25, Township, or other)
- ☐ Letter of denial of benefits (Medi-Cal, insurance, or other)
- ☐ Proof of outstanding circumstance or medical expense

If you have any questions, please contact us at **650-434-2181** or **contact@pacifichearingconnection.org**. You may submit your documents by email, fax, dropping them off at our office, or mailing our office at:

Pacific Hearing Connection
496 1st Street, Ste 120
Los Altos, CA 94025

PACIFIC Hearing CONNECTION

VOLUNTEER SERVICE FORM

Patient Name: _____

Organization for Proposed Activity: _____

Organization Phone #: _____

Organization Address: _____

Organization Supervisor: _____

Please provide a brief description of your proposed volunteer activity:

_____

_____

_____

_____

Hours Required: _____ **Approved by:** _____ **Date:** _____

Pacific Hearing Connection use only.

LOG

Date	Hours Completed	Supervisor Signature

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FAQ

How do I know if I qualify for PHC?

The table below shows the guidelines we use to determine qualifying annual income by the number of people in your household. All income earned in the family is counted towards your annual income.

People living in your home:	Household Income is at or below:
1	$101,520
2	$116,000
3	$130,560
4	$145,040
5	$156,640
6	$168,240
7	$179,840
8	$191,440

What is the process for getting hearing aids through PHC?

1. The patient submits a completed New Patient Application.
2. PHC reviews the information and determines the patient's eligibility, sliding scale fees, and required volunteer hours.
3. Upon approval, PHC will contact the patient to schedule a hearing test. The patient may choose to get the test done at another facility and provide PHC with a copy. If the patient has an existing test from within 1 year, PHC can use those results and the patient does not have to be retested.
4. The patient meets with the audiologist to determine what hearing aid will be fit, and what volunteer activity will be performed.
5. PHC will either select the hearing aid from our refurbished donations, or order the hearing aid as necessary.
6. Once ½ of the volunteer hours have been completed, PHC will schedule the fitting appointment.
7. The patient meets with the audiologist to fit and program the hearing aid. Payment for the hearing aid is due at this time.
8. The patient will follow up with the audiologist within the next month to make adjustments and ensure everything is going well.

Why do I need to complete volunteer service hours to receive hearing aids if I am paying a sliding scale fee?

As a nonprofit serving low-income individuals, we have limited resources. We rely on donations, grants, volunteers, and other sources of income to be sustainable. Our volunteer service program allows us to thank our community for supporting our organization and making it possible to offer the reduced fees on the sliding scale fee basis. If you physically cannot do your volunteer service, our provisions allow for a loved one, friend, or other person to complete your hours on your behalf.