www.gracehearing.org

Hello,

We are so glad that you have learned about our new program, and we are excited to begin serving you for all your future hearing healthcare needs should you decide to continue with us. Grace Hearing Center, Inc. is a 501c3 nonprofit organization established to meet the hearing needs for low-income children and adults in Tucson. 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 not otherwise afford it. Grace Hearing Center operates with a Circle of Giving model which gives all patients the opportunity to pay the kindness they have received forward by participating in assigned community service hours that help to offset the cost of services.

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 what documentation we require to apply for our program. Enclosed is a required documents list, a copy of our patient intake form, and HIPAA disclosure. At your earliest convenience, please fill out the intake form and submit a copy of the required documentation to apply to our program so that you can begin receiving services as you need them in the future. If you have any questions about this process or about the required paperwork, please do not hesitate to call us at (520) 468-9976.

Once your application is complete, you may submit it to us in person at either of the two locations:

2919 E Broadway Blvd, Suite 110
Tucson, AZ 85716
Open Tuesdays 8-4pm

2542 E Vistoso Commerce Loop
Oro Valley, AZ 85755
Open Monday - Friday 8-4 pm

Or you may mail it to us at:

Attn: Grace Hearing Center
2542 E Vistoso Commerce Loop
Oro Valley, AZ 85755

Sincerely,

Grace Hearing Center
2919 E Broadway Blvd, Suite 110
Tucson, AZ 85716
gracehearing@hearintucson.com
Open Tuesdays 8-4pm by appointment only.

GRACE HEARING CENTER INC

Income & Verification Worksheet

You need to turn in these documents

o Copy of Driver's License or State ID and/or Medicaid ID

o Most Recent Paystubs (need at least 2)

o Most Recent Income Tax Return (last year or two years)

o Bank Statement (last 60 days)

o IRA/Investment Income/401K/Stocks/Bonds or other assets

o Proof of Residence (utility bill, lease, or other)

o Proof of Social Security or Disability Income

o Proof of Unemployment Income

o Proof of TANF, Food Stamps, or other Financial Assistance Income

o Letter of Referral/Support, or Denial of Services (Catholic Charities, or Other Service agencies)

o Letter of Denial of Benefits (Medicaid, Insurance, or Other)

o Letter of Outstanding circumstance or Medical Expenses

For Office Use Only.

Monthly Income_____ Annual Income_____

Household Size_____ Total Assets/Savings_____

Sliding Scale Discount Percentage:_____ Volunteer Hours_____

Patient Signature: _____ Date: _____

Grace Hearing Representative: _____ Date:_____

Maximum Savings/Retirement/IRA/Cash Flow Verification:

If unable to provide verification of savings, IRA/Investment Income/401K/Stocks/Bonds or other assets please initial each line and send back to:

2542 E Vistoso Commerce Loop
Oro Valley Audiology
Oro Valley, AZ 85755

Have no more than $10,000 in cash reserves and/or savings: _____

Have no more than $50,000 of accessible finances in Retirement and/or Investments: _____

Have no more than $100,000 of accessible finances in Retirement and/or Investments:_____

Unable to provide proof of household* income and assets:_____

**"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 age 18 is living in the home and paying rent/sharing expenses (documented), he/she can be classified as a border and their portion of rent will only be attributed as income to the household. Note: if an adult living in the home is receiving more than 50% of his/her support (financial, food, shelter, etc.) from others in the home, he/she is considered a part of the household and therefore the financial head of the household's income will be considered when determining eligibility of services.

I , _____(print name), hereby attest that the above statements are true.

Patient Signature:_____
Date: _____

For Office Use Only:

Total Assets/Savings:_____

Sliding Scale Discount Percentage:_____

Volunteer Hours:_____

Grace Hearing Representative:_____

Date:_____

GRACE HEARING CENTER INC

Sliding Fee Scale: Form

Patient Information			Today's Date: / /	
First Name:	Middle:	Last:	Other names:	
Home Address:		City:	State:	Zip:
Mailing Address:		City:	State:	Zip:
Home Phone #: ( ) -		Cell Phone #: ( ) -		
Date of Birth: / /	Social Security # - -		Do you have insurance? (circle one) Yes No	
Marital Status:	Single In a relationship Married Divorced Separated Widowed			

Household Size		
Name	**Date of Birth**	**Social Security Number**
	/ /	- -
	/ /	- -
	/ /	- -
	/ /	- -
	/ /	- -

NOTE: To comply with federal regulations, in order to give you a discount on our medical services, it is necessary for us to ask some personal questions. Your answers will be kept on file and in strict confidence. You must verify your income at least every year.
Your yearly income tax return, a copy of your W-2 form, last month's paycheck stubs, copies of your social security checks, or other checks you may receive will be sufficient proof. Your annual income and your family size will be used to calculate your discount.

Household Income

Name	Amount	Frequency (Circle one)	Employer:
You	$	Weekly Monthly Yearly	
Spouse	$	Weekly Monthly Yearly	
Children	$	Weekly Monthly Yearly	
Other	$	Weekly Monthly Yearly	
	$	Weekly Monthly Yearly	
TOTAL	$	Weekly Monthly Yearly	

Other Income	You	Spouse	Children	Other	Subtotal
Social Security					
Public Assistance					
Retirement Pension					
Food Stamps					
Child Support, Alimony					
Interest Income					
Other					
				TOTAL	**$**

Sliding Fee Scale:
A – Nominal Fee

B – 75% Discount

C – 65% Discount

D – 50% Discount

E – 25% Discount

F – 0%Discount

I do hereby swear or affirm that the information provided on this application is true and correct to the best of my knowledge and belief. I agree that any misleading or falsified information, and/or omissions may disqualify me from further consideration for the sliding fee program and will subject me to penalties under Federal Laws which may include fines and imprisonment. I further agree to inform Grace Hearing Center if there is a significant change in my income. If acceptance to the sliding fee program is obtained under this application, I will comply with all rules and regulations of Grace Hearing Center. I hereby acknowledge that I read the foregoing disclosure and understand it.

Date: _____ Name (Print):_____

Signature: _____

GRACE HEARING CENTER INC

Financial Guidelines for Services

	A	B	C	D	E	F	
	100% FPL	125% FPL	150% FPL	175% FPL	185% FPL	MAX 250% FPL	Cust EM
volunteer hours	*36*	*28*	*20*	*16*	*12*	*8*	
Used Hearing Aid	$100	$150	$250	$300	$375	$450	$65
High-Used Hearing Aid	$150	$190	$295	$325	$425	$500	
New Hearing Aid	$450	$500	$525	$500	$650	$850	
Cochlear Accessories							
Up to $1000/item	50% off	40% off	30% off	20% off	10% off	Cost	

** Does not include processor replacement*

Family Size

	**Nominal Fee*	*75% off*	*65% off*	*50% off*	*25% off*	*Pay 100%*
1	14,580	18,225	21,870	25,515	26,973	36,450
2	19,720	24,650	29,580	34,510	36,482	49,300
3	24,860	31,075	37,290	43,505	45,991	62,150
4	30,000	37,500	45,000	52,500	55,500	75,000
5	35,140	43,925	52,710	61,495	65,009	87,850
6	40,280	50,350	60,420	70,490	74,518	100,700
7	45,420	56,775	68,130	79,485	84,027	113,550
8	50,560	63,200	75,840	88,480	93,536	126,400

Add $4180/year for every additional person in household over 8.

Maximum Savings/Retirement/IRA/Cash Flow:

If more than $10,000 in cash reserves and/or savings, patient will self pay at 100% of services & fees.

If more than $50,000 of accessible finances in Retirement and/or Investments, patient will self pay at 100% of service

If more than $100,000 of accessible finances in Retirement and/or Investments, patients will not qualify for the progr

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 age 18 is living in the home and paying rent/sharing expenses (documented), he/she can be classified as a border and their portion of rent only will be attributed as income to the household.

Note: if an adult living in the home is receiving more than 50% of his/her support (financial, food, shelter,etc.) from others in the home, he/she is considered a part of the household and therefore the financial head of household's income will be considered when determining eligibility of services.

Rev. 11-2023

**Nomial Fee*	
$5	$5-$25
$10	$26-$50
$20	$51-$100
$25	$101-$150
$35	$151-$200
$45	$201-$250
$55	$251-$300
$65	$301-$400
$100	$800

GRACE HEARING CENTER INC

www.gracehearing.org

We cannot test, provide services, or submit claims without this information.

Patient Information *(Please Print):*

Name: _____
First Name Middle Initial Last Name

Date of Birth: _____ Referral Source: _____

Address: _____

City_____ State_____ Zip_____

Home Phone: _____Cell Phone: _____ Work_____
Email address: _____
Name of Parent (if applicable) _____

Emergency Contact_____ **Phone** _____

Primary Care Physician (PCP): _____
PCP's Full Address: _____
PCP's Phone #: _____ Fax #:_____

Do you wear hearing aids? Yes/No Model: _____
Serial Number(s) - Right: _____ Left: _____

I authorize the release of any medical or other information necessary to process this claim through my insurance. I authorize payment of medical benefits to the assigned physician or supplier for services rendered.

Signature of Patient: _____**Date:** _____

GRACE HEARING CENTER INC

Confidential Medical and Hearing Health History

It is important that we know all of your medical and hearing health history. Many items have a direct bearing on your hearing health (including the state of your ear canals). We will review the questionnaire and discuss in detail those items that may be of concern. Information you share with us is **strictly confidential** and will not be released without your approval.

NAME: _____ **DOB:** _____

Doctor's name: _____

REFERRAL SOURCE

_____ Failed screening

_____ Friend/Patient_____

_____ Other (website/letter/newspaper)_____

Please circle or complete the following questions:

1) **Have you had your hearing tested before?** ..... Yes No Unsure
   What year? _____ Where? _____

2) **Do you have ANY problem hearing?** ..... Yes No Unsure
   How long? _____Which ear? Right ___ Left ___ Both ___

3) **Have you ever worn hearing aids?** ..... Yes No
   How long? _____Which ear? Right ___ Left ___ Both ___

4) **Do family/friends comment about your having difficulty hearing?** .... Yes No Unsure

5) **Anyone in your family, including first cousins, have a hearing loss?** Yes No Unsure
   Who? _____

6) **Are you currently, or have you ever been, exposed to noise/acoustical trauma (i.e. ANY hunting, target practice, power tools, motocross, etc.)**? .... Yes No

7) **Do you hear noises (tinnitus) in your ears or head?** ..... Yes No Unsure
   Right ___ Left ___ Both ___ Constantly ___ Occasionally ___ Unsure ___

8) **Have you had any ear infections?** ..... Yes No Unsure
   When? _____ Right ___ Left ___ Both ___

9) **Have you had any ear surgery?** ..... Yes No Unsure
   When? _____ Right ___ Left ___ Both ___

10) **Do you take medications regularly, including over-the-counter and herbal supplements?** ..... Yes No
    ****Does this include a blood thinner?** ..... Yes No

11) **Do you smoke? If Yes, How often _____Type of Smoking_____** Yes No

<u>Please turn page over to complete this form.</u>

Do you have or have you had:

1.	**Allergies ……...……**	**Yes**	**No**	**Unsure**
2.	**Arthritis ……..…….……**	**Yes**	**No**	**Unsure**
3.	**Blood disorder, such as hemophilia ...……**	**Yes**	**No**	**Unsure**
4.	**Cardiovascular disease: arteriosclerosis, high blood pressure, stroke, coronary insufficiency/occlusion, heart trouble, heart attack……..**	**Yes**	**No**	**Unsure**
5.	**Chemotherapy or radiation treatment ……..**	**Yes**	**No**	**Unsure**
6.	**Diabetes …….……**	**Yes**	**No**	**Unsure**
7.	**Dizziness/balance problems……..**	**Yes**	**No**	**Unsure**
8.	**Ear pain or fullness ……**	**Yes**	**No**	**Unsure**
9.	**Fainting spells or seizures ….……..**	**Yes**	**No**	**Unsure**
10.	**Headaches ……..**	**Yes**	**No**	**Unsure**
11.	**Hives or skin rash, skin allergies ……..……....**	**Yes**	**No**	**Unsure**
12.	**Pacemaker....……...**	**Yes**	**No**	**Unsure**
13.	**Persistent cough or cough up blood....…….……..**	**Yes**	**No**	**Unsure**
14.	**Preeclampsia (women)...……..…..……..**	**Yes**	**No**	**Unsure**
15.	**Significant weight loss in the last two years……...……..**	**Yes**	**No**	**Unsure**
16.	**Sinus trouble ……..……**	**Yes**	**No**	**Unsure**
17.	**Skull fracture or concussion ……..**	**Yes**	**No**	**Unsure**
18.	**Have you had any surgery including hip replacement? ……..……** **If yes, please list: _____**	**Yes**	**No**	**Unsure**
19.	**Have you had any serious illnesses? …….…… ** **If yes, please list: _____**	**Yes**	**No**	**Unsure**
20.	**Do you have any other diseases, conditions or special concerns <u>not listed above</u> that you think we should know about? _____**			

I certify that I have read and understood the above. I acknowledge that my questions, if any, about the inquires set forth above have been answered to my satisfaction. I will not hold my audiologist, or any other member of this staff, responsible for any errors or omissions that I may have made in completion of this form. I also agree to notify Grace Hearing Center of any changes in my medical status. I agree to allow the Audiologist to practice within the limits of their license.

Signature of Patient_____

Date

GRACE HEARING CENTER INC

www.gracehearing.org

2919 E Broadway Blvd Ste 110
Tucson, AZ 85716
(520) 468-9976

As part of your medical history, please list your current (within the last 6 months) medications, vitamins, and supplements that you are using.

MEDICATION NAME	DOSAGE	FREQUENCY	ROUTE (ORAL,IV, ETC)
SIGNATURE:		DATE:	

NOTICE OF PRIVACY PRACTICES
Effective August 7, 2019

Notice of Privacy Practices for Protected Health Information

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

How we may use and disclose your health information. We are required by law to give you this Notice explaining that we use and disclose your health information for the following purposes:

- **Treatment.** We will use your health information to provide you with health care services and products. We may share your health information with health care professionals who are involved in your care and who are part of the entity providing your care.
- **Payment.** We may use and disclose health information about you so that we can bill any applicable payors or programs for your health care services or products. If your insurer or health plan requires prior approval or other notice in order to determine whether they will pay for those services or products, we may disclose your health information to them – unless you have asked that we not bill your insurer or plan.
- **Health Care Operations.** We may use and disclose information about you within our company to manage and improve our business. This includes quality assessment activities, licensing and accreditation activities, obtaining legal and accounting services, and business planning and management. Other people and companies who are not employees or affiliates of Oro Valley Audiology may help us run our business. These people and/or companies are our "business associates." We may give them limited access to your health information to do what we have hired them to do and they agree to safeguard your information.
- **Individuals Involved in Your Care.** If you agree, we may give certain health information about you to a friend or family member involved in your care or obtaining payment related to your care. If you cannot agree because of incapacity or emergency circumstances, we may disclose your health information as necessary if we determine that is in your best interest, based on our professional judgement.
- **Research**. We will not use or disclose health information that identifies you for research purposes unless you agree in writing or the use or disclosure complies with applicable law and a privacy board or institutional review board approves the arrangement.

Additionally, we may use or disclose your health information, without your authorization, for the following purposes:

- As authorized by and to the extent necessary to comply with workers' compensation or similar laws;
- For public health activities, as permitted or required by law, such as preventing or controlling disease and reporting suspected abuse or neglect;
- To a health oversight agency for adults, investigations, inspections, and licensure activities;
- To a law enforcement official in response to a court order, subpoena, warrant, summons or similar process; to identify or locate a suspect, witness, or missing person or as required by law;
- To a court or party in litigation in response to a valid court or administrative order;
- If you are an inmate of a correctional institution, to the institution as necessary for your health and the health and safety of other individuals;
- For military, national security or lawful intelligence activities; or
- As otherwise permitted or required by law.

Uses and disclosures of your health information, other than those described above, will be made only with your written authorization. You may revoke that authorization in writing at any time, but we cannot take back any disclosures we already made in reliance on a previous authorization.

Your Rights to Your Health Information. You have the following rights regarding the health information we maintain about you:

- **Right to Inspect and Copy**. With some exceptions, you have the right to inspect and request a copy of your records if we have or use those records and they include health information about you. We have the right to collect the current rate of $0.50/page for making copies of your record.
- **Right to Amend**. If you feel that a record containing your health information is incorrect or incomplete, you may ask us to amend the information. You must tell us why you think the information is wrong or incomplete. We may deny your request if (among other reasons) the information was not created by us; is not included in your medical, billing or other records used to make decisions about your care; or is otherwise accurate and complete.
- **Right to an Accounting of Disclosures**. With limited exceptions, you have the right to request a written accounting of every disclosure of your health information we have made for up to six years prior to your request, other than disclosures to you, disclosures authorized by you in writing, and disclosures for treatment, payment and health care operations as described in this Notice. Your request must state a time period, which may not be longer than six years prior to this date and may not include dates before April 14, 2003.
- **Right to Receive a Breach Notification**. If a breach involving your health information occurs, you have the right to be notified of the circumstances.
- **Right to Authorize Marketing Communications or Sale of Health Information**. In instances where we may receive financial remuneration in exchange for making a communication about a health-related product or sale of your health information, you have the right to be notified and specifically provide or deny authorization of this use or disclosure.
- **Right to Request Restrictions**. You have the right to request a restriction or limitation on the health information we use or disclose about you for treatment, payment, health care operations, or to assist others' involvement in your care. We are not required to agree to your request. If we do agree, we will comply with your request unless the information is needed to provide you emergency treatment. In your request, you must tell us (1) what information you want to limit; (2) whether and how you want to limit our use, disclosure or both; and (3) to whom you want the limits to apply (for example, disclosures to your spouse). You have the right to restrict disclosures of your protected health information to a health plan if you pay out of pocket in full for the item or service.
- **Right to Request Confidential Communication**. You have the right to request that we communicate health information about you in a certain way or at a certain location. For example, you can ask that we only contact you at work or by mail.

To pursue any of the above listed rights, you must submit your request in writing to our Privacy Officer, at the address listed at the end of this Notice. Your request should indicate in what form you want the reply (for example, on paper or by e-mail). We reserve the right to charge you for copying and providing further information in response to your request. We will notify you of the cost involved and you may choose to withdraw or modify your request at that time before any costs are incurred.

Our Legal Duties and Rights. We are required by law to protect the privacy of your health information and to provide this Notice about our legal duties and health information practices. We will comply with this Notice. We reserve the right to change our health information practices and the terms of this Notice. We reserve the right to make the changed Notice effective for health information we already have about you as well as any information we receive after the change. The Notice will contain an effective date on the first page, in the top left-hand corner. We will post a copy of the current Notice on our website, www.hearintucson.com.

Complaints. If you believe your privacy rights have been violated, you may file a complaint with the Privacy Office at the address listed immediately below. You may also file a complaint with the Secretary of the Department of Health and Human Services, Office for Civil Rights. For complete instructions on filing with the OCR, please visit www.hhs.gov. You will not be penalized for filing a complaint.

If you have any questions please contact our Privacy Office Judy Huch, in writing, to 2542 E Vistoso Commerce Loop, Oro Valley, AZ 85755.

Patient Name	Signature	Date

Financial Policy

Welcome to our office! We are pleased that you have chosen Grace Hearing Center to provide your care and service. We want to take a moment of your time to inform you of our policies regarding payment with our office. We accept cash, personal checks, and credit cards for payment on your account.

INSURANCE: We do not accept insurance and we expect you to pay for your visit at the time of service.

RETURNED CHECKS: In the event your bank returns your check to our office unpaid, there will be a $25.00 return check fee charged to your account.

NON-PAYMENT: In the event your account becomes delinquent, you will be responsible not only for charges incurred but also any costs involved in collection on your account. A collection agency may be used to collect on delinquent accounts. You are ultimately responsible for the payment on your account.

If you have any questions regarding our payment policies, please ask us before your visit. Thank You!

I have read and understand the payment policies set forth and have been given the opportunity to ask questions about this policy. I understand my responsibility for payment of my account with Grace Hearing Center and have provided to the best of my ability the information requested accurately and completely.

_____ _____

Signature Date

Revised 2021

Permission to Use Photograph

Subject: _____
Location: _____

I grant to Grace Hearing Center, Inc., its representatives, and employees the right to take photographs or videos of me and my property in connection with the above-identified subject. I authorize Grace Hearing Center, Inc. its assigns and transferees to copyright, use and publish the same in print and/or electronically.

I grant that Grace Hearing Center, Inc. may use such photographs or videos of me with or without my name and for any lawful purpose, including for example such purposes as publicity, illustration, advertising, and Web content, and social media.

Organization Name: Grace Hearing Center, Inc
Address: 2919 E. Broadway Blvd Ste.110 Tucson, AZ 85716

I have read and understood the above:

Signature _____
Printed name _____
Date _____

Signature, parent or guardian _____
(if under age 18)

Revised 2021