



AFFORDABLE CARE APPLICATION

Happy Ears Audiology LLC has established an Affordable Care Plan to reduce the cost of clinical services and hearing devices. In order to be considered, please complete and submit this form via email to info@happyyearsaudiology.org or fax to **740-538-5602**.

Patient Name: _____ **Title:** _____
First Last MI

Date of Birth: _____ **Age:** _____ **Sex:** Male | Female

Mailing Address: _____
Street City State Zip

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

Email Address: _____

Number of People in Household (circle one): 1 2 3 4 5 6 7 8 9+

Employed By: _____ **Title:** _____

Marital Status (circle one): Single Married Divorced Widowed Domestic Partnership

Spouse's Name: _____ **Employer:** _____

Referred By: _____

Insurance Type: None | Medicaid | Medicare | Other (please list): _____

Do you have a hearing aid benefit through your insurance? Yes | No

Yearly Income (All Sources): _____

I understand that approval of this assistance does not release me from the obligation to pay the remaining charges upon receipt of my statement. The information I provided on this form is accurate and true.

Signature Name of Patient or Personal Representative

Date

Non-Discrimination Policy: It is the commitment and policy of Happy Ears Audiology that we do 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.



Eligibility Document Checklist

Patient Name: _____ Date of Birth: _____

Please make copies of the following items that apply to you and your household and **include them with your application packet**. Please note that the below table is meant to cover most cases, but it is normal for only a few rows to be relevant to you. If you have other sources of income not listed, it should be included.

Directions:

- Circle “Yes” to indicate that the document listed is included in your packet OR circle “Not Applicable” for documents that do not apply to you or your household members.
- **Income amount must be listed and proof provided for each applicable document for each household member age 18 and over.**

Item	Applicable?	Income Amount or Account Balance
Current Audiogram (performed within last twelve months; can be performed with our office post-approval)	Required	N/A
Copy of Driver's License or State ID	Required	N/A
Copy of Insurance Card (for example: Medicare or Medicaid ID)	Yes Not Applicable	N/A
Most Recent Pay Stubs (at least 3)	Yes Not Applicable	\$_____/month
Bank Statements from Checking & Savings Accounts (last 90 days)	Yes Not Applicable	Balance: \$_____
Proof of: Child/Spousal Support Income	Yes Not Applicable	\$_____/month
Proof of: Social Security or Disability Income	Yes Not Applicable	\$_____/month
Proof of: Unemployment Income	Yes Not Applicable	\$_____/month
Proof of: TANF / Food Stamps / Other Financial Assistance Income	Yes Not Applicable	\$_____/month
Other Income (anything not yet mentioned, such as investments or family support or anything else)	Yes Not Applicable	\$_____/month
Proof of: Extenuating Circumstances and/or Hardships (such as recurring medical bills)	Yes Not Applicable	N/A