DC | HEALTH
GOVERNMENT OF THE DISTRICT OF COLUMBIA

# HEARING AID ASSISTANCE PROGRAM APPLICATON INSTRUCTIONS

Thank you for your interest in the **District of Columbia Hearing Aid Assistance Program (HAAP)**. Below are instructions to apply for reimbursement.

**STEP 1.**
To apply for reimbursement, fill out the application form. If applicant is under 18, please pay close attention to questions that ask for information for the applicant's guardian.

**SECTION I: General Information (p*lease print clearly*)**

1. **Date of Application –** Enter today's date. (*MM/DD/YY*)
2. **Applicant's First Name –** Enter First Name. (e.g. *John*)
3. **Middle Initial –** Enter Middle Initial. (e.g. *I.*)
4. **Last Name –** Enter Last Name (e.g. *Doe*)
5. **Birthdate –** Enter the birthdate (*MM/DD/YY*)
6. **Applicant's Age –** Enter the applicant's age (e.g. *6*)
7. **Gender –** Select gender from dropdown menu. For "other" please fill in.
8. **Race –** Select race from dropdown menu.
9. **Ethnicity –** Select ethnicity from menu.
10. **Mailing Address –** Enter mailing address. (e.g. *123 Anyroad St, NE*)
11. **Zip –** Enter zip code. (e.g. *20002*)
12. **Ward –** Enter the ward that applicant lives in. If unknown; leave blank. (e.g. *Ward 6*)
13. **Home Phone –** Enter applicant home telephone number, if applicable. (e.g. *202-123-1234*)
14. **Cell/Mobile Phone –** Enter applicant's cell phone number. (e.g. *202.123.4567*)
15. **Email Address –** Enter applicant's email address. (e.g. *johndoe@xyz.com*)
16. **Level of Education –** Select the applicant's highest level of education from dropdown menu or paper application.
17. **Employment Status –** Select applicant's current employment status from dropdown menu or paper application.
18. **Name of Current Employer (Parent/Guardian info if applicant under 18) –** Enter the name of applicant's current employer. (e.g. *ABC Corporation*)
19. **How long have you been employed there?** – Enter the length of time applicant has been employed with the current employer. (e.g. *1-2 years*)

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**SECTION I.A: Parent/Guardian Information. If applicant is under 18 years old, please complete this section for Parent/Guardian (p*lease print clearly*).**

20. **Name of Parent/Guardian (if applicant is under 18) –** Enter name of parent or guardian. (e.g. *Jane Doe*)
21. **Relationship to Applicant –** Enter guardian's relationship to applicant. (e.g. *mother*)
22. **Cell/Mobile Phone –** Enter guardian's cell phone number. (e.g. *202.123.4567*)
23. **Email Address –** Enter guardian's email address. (e.g. *johndoe@xyz.com*)
24. **Employment Status –** Select guardian's current employment status from dropdown menu or paper application.
25. **Name of Current Employer –** Enter the name of guardian's current employer. (e.g. *ABC Corporation*)
26. **How long have you been employed there?** – Enter the length of time guardian has been employed with current employer.

## Section II: Household and Financial Information

27. **Number in household –** Select household size from dropdown menu or write in if paper application. Household is defined as all those who live together or are dependent on each other. (e.g. *4*)
28. **Income (salary range) –** Select salary range from dropdown menu or paper application of applicant household.
29. **Number and ages of persons dependent on this income –** Enter the number of dependents in the household and their age(s). (e.g. *2 dependents, ages 15 and 10*)

## Section III: Health Information

30. **Does the applicant have health insurance?** – Select whether applicant is insured, uninsured, or unknown.
31. **If insured, what type of insurance does the applicant have?** – Select the type of insurance that applicant has from dropdown menu or paper application (e.g. Medicaid).
32. **Does the applicant currently have a disability? –** Select the disability status of the applicant. (e.g. *yes*)
33. **If yes, please select current disability status** – Select the disabilities that apply for the applicant.

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34. **Does applicant currently have a diagnosis of any chronic condition?** – Select yes, no, or unknown.
35. **If yes, please list applicant's chronic condition(s) below: –** Select the chronic condition(s) applicable. If other, please write in the chronic condition(s).
36. **Does applicant have a Primary Care Provider?** – Select yes or no.
37. **Does applicant currently have a hearing aid?** – Select yes or no.
38. **If yes, please enter the date of purchase** – Enter the date the hearing aid was purchased.
39. **Cost of Hearing Aid: –** Enter the total cost of the hearing aid.
40. **How did applicant learn about this program?** – Please enter how applicant learned about the program. (e.g. *physician's office, DC Health, etc.*)

## Section IV: Medical Clearance (*must be completed by a physician*)

41. **Physician Name (please print): –** Enter the name of applicant's physician/doctor. (e.g. *Dr. James Doe*)
42. **Physician Address: –** Enter the address of physician/doctor's office. (e.g. *234 Anystreet Road, NW*)
43. **City: –** Enter the city in which physician/doctor's office is located. (e.g. *Washington*)
44. **State: –** Enter the state in which physician/doctor's office is located. (e.g. *DC*)
45. **Zip: –** Enter physician/doctor's office zip code. (e.g. *20001*)
46. **Ward: –** Enter the ward that physician's office is located. If unknown; leave blank. (e.g. *Ward 6*)
47. **Physician Phone Number –** Enter physician/doctor's office number. (e.g. *202-678-1234*)
48. **National Provider Identifier (NPI) # –** NPI is a unique identification number for health care providers. Enter the NPI number of applicant's physician/doctor. Applicant should be able to get this information from the physician/doctor's office.

## Section V: Attestation

49. **Signature of Physician – For paper applications, have your physician sign the Medical Clearance section of the application.** ***For electronic applications, please include a doctor's note that confirms that the physician has evaluated applicant and has found that applicant has a hearing loss that makes applicant a candidate for a hearing aid. There is no medical contraindication for amplification.***
**Attestation of application's correctness –** Please read the acknowledgement language and select yes or no to confirm all the information in the application is correct to the best of your knowledge.

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50. **Applicant's Name –** Enter the applicant's name. (e.g. *John Doe*)
51. **Parent/Guardian Name (if applicant is under 18 years old) –** Enter name of parent or guardian. (e.g. *Jane Doe*)
52. **Applicant or Parent/Guardian Signature –** Sign the application. The parent/guardian should sign if the applicant is under 18 years old.
53. **Date –** MM/DD/YY

## Section VI: Attachments

54. **Attachments –** Confirm all required documents have been uploaded to the electronic application or included in the paper application submission.

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**STEP 2.**
Gather and attached the necessary supporting documentation as proof of eligibility. The table below provides examples of what documentation will qualify as proof:

| Proof of: | Examples |
|---|---|
| **Income** | Recent paystubs; statement showing retirement income, disability income, or Workers Compensation; pension statement, etc. |
| **DC Residency** | DC driver's license, lease, rent receipt, written statement from your landlord, utility or telephone bill, etc. |
| **Rent/Mortgage** | Lease, rent receipt, cancelled check, mortgage statement, etc. |
| **Utility Bills** | Recent bills for electric, gas, fuel, phone, water, telephone, etc. (if you pay these separately from your rent). |
| **Relationship** | Birth certificate (complete copy) for your dependent child(ren) or official records from a school, court, hospital, etc. |
| ****"Living with"** | Statements from two non-relatives or school records. |
| **Medical Certification** | Signed statement for your physician |

**If applicant does not have their own place of residence and is currently living with someone else.

**STEP 3.**
Submit the application and all of the required supporting documents. The application can be completed and submitted in the following ways:

1. Complete the application and upload the supporting documentation online at https://dchealth.dc.gov/page/health-care-access-bureau. Applications and documentation can be submitted using a desktop computer, tablet, or smartphone.

2. Download, print and submit your completed application and supporting documentation:
   a. By email – applications and supporting documentation can be sent to tmoses@smsllcgroup.com.
   b. By mail – please send completed applications and supporting documentation to Strategic Management Services, LLC, 137 National Plaza, Suite, 300, National Harbor, MD 20745.
   c. By fax – please fax applications and supporting documentation to (*insert fax number*).

For more information about the District of Columbia Hearing Aid Assistance Program (HAAP), visit https://dchealth.dc.gov/page/health-care-access-bureau or contact tmoses@smsllcgroup.com or (202) 656-3027.