DC | HEALTH
GOVERNMENT OF THE DISTRICT OF COLUMBIA

# HEARING AID ASSISTANCE PROGRAM APPLICATION

**The District of Columbia's Hearing Aid Assistance Program (HAAP) provides District of Columbia residents with a reimbursement of up to $500 to offset the cost of purchasing a hearing aid that was not covered by insurance.**

To be eligible for the reimbursement, applicants must:

- Provide proof of District of Columbia residency;
- Meet at least one of the following criteria;
  - 0-14 years of age
  - 65 years of age or older
  - Have a disability
- Have an annual household gross income of less than $100,000 (see guidelines below);
- Provide a hearing aid receipt from an authorized medical device supplier; and
- Provide a written statement from a physician confirming the medical necessity for obtaining a hearing aid or have the Medical Clearance Section completed and signed by a physician.

| Person(s) in Household | D.C. Poverty Guidelines (Annual) | | | | | |
|---|---|---|---|---|---|---|
| | 100% | 133% | 138% | 150% | 200% | 250% |
| 1 | $12,760 | $16,971 | $17,609 | $19,140 | $25,520 | $31,900 |
| 2 | $17,240 | $22,929 | $23,791 | $25,860 | $34,480 | $43,100 |
| 3 | $21,720 | $28,888 | $29,974 | $32,580 | $43,440 | $54,300 |
| 4 | $26,200 | $34,846 | $36,156 | $39,300 | $52,400 | $65,500 |
| 5 | $30,680 | $40,804 | $42,338 | $46,020 | $61,360 | $76,700 |
| 6 | $35,160 | $46,763 | $48,521 | $52,740 | $70,320 | $87,900 |
| 7 | $39,640 | $52,721 | $54,703 | $59,460 | $79,280 | $99,100 |
| 8 | $44,120 | $58,680 | $60,886 | $66,180 | $88,240 | $100,00 |

**To be considered for HAAP reimbursement, the complete application must be submitted with the necessary supporting documentation. Applications can be submitted via email at tmoses@smsllcgroup.com or mailed to the Strategic Management Services, LLC, 137 National Plaza, Suite, 300, National Harbor, MD 20745.**

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

Date of Application: _____ Applicant's Birthdate: _____ Applicant's Age: _____

Applicant's Gender: ☐ Male ☐ Female ☐ Other _____

Applicant's First Name: _____ Middle Initial: _____ Last: _____

Applicant's DC Mailing Address: _____ Apt #: _____

City: Washington State: DC Zip: _____ Ward: _____

Home Phone: _____ Cell/Mobile Phone: _____

Email Address: _____

Applicant's Race:

☐ American Indian or Alaska Native
☐ Asian
☐ Black or African American
☐ ☐ Native Hawaiian or Other Pacific Islander
☐ ☐ White
☐ ☐ Other _____

Applicant's Ethnicity: ☐ Hispanic/Latino ☐ Not Hispanic/Latino

Which of the following best describes applicant's highest level of completed education?

☐ Never attended school or only attended kindergarten
☐ Grades 1 through 8 (Elementary)
☐ Grades 9 through 11 (Some High School)
☐ Grade 12 or GED (High School Graduate)
☐ College 1 year to 3 years (Some College or Technical School)
☐ 4 years or more (College Graduate)
☐ Choose not to answer

Which of the following best describes the applicant's employment status?

☐ Employed for wages
☐ Self-employed
☐ Out of work for less than 1 year
☐ Out of work for 1 year or more
☐ Homemaker
☐ Student
☐ Retired
☐ Unable to work

Name of Current Employer of applicant: _____

How long has the applicant been employed there? _____ (years) _____(months)

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

**Parent/Guardian's name**: _____

**Relationship to applicant**: _____

Home Phone: _____ Cell/Mobile Phone: _____

Email Address: _____

Which of the following best describes the **Parent/Guardian's** employment status?

- ☐ Employed for wages
- ☐ Self-employed
- ☐ Out of work for less than 1 year
- ☐ Out of work for 1 year or more
- ☐ Homemaker
- ☐ Student
- ☐ Retired
- ☐ Unable to work
- ☐ Refuse to report

Name of Current Employer of **Parent/Guardian**: _____

_____

How long has the **parent/guardian** been employed there? _____ (years)_____(months)

**Section II: Household and Financial Information**

Number of People Living in Applicant's Household: _____
*(Household is defined as all those who live together or are dependent on each other.)*

Which of the following best describes the household's income annually?

- ☐ Less than $10,000
- ☐ $10,000 to $15,000
- ☐ $15,001 to $20,000
- ☐ $20,001 to $25,000
- ☐ $25,001 to $30,000
- ☐ $30,001 to $35,000
- ☐ $35,001 to $50,000
- ☐ $50,001 to $75,000
- ☐ $75,001 to $100,000

Number and ages of persons dependent on this income:

_____ , _____ , _____ , _____ , _____ , _____, _____, _____

## Section III: Health Information

Which best describes the applicant's insurance status?

- ☐ Insured
- ☐ Uninsured
- ☐ Unknown

If insured, what type of health insurance does applicant have?

- ☐ Alliance
- ☐ Medicaid
- ☐ Medicare
- ☐ Other Public Insurance _____
- ☐ ☐ Private Insurance
- ☐ ☐ None/Does not have any health insurance
- ☐ ☐ Unknown

Does the applicant currently have a disability?

- ☐ Yes
- ☐ No
- ☐ Unknown

If yes, which of the following best describes applicant's disability?

- ☐ Musculoskeletal System
- ☐ Special Senses and Speech
- ☐ Respiratory Disorders
- ☐ Cardiovascular System
- ☐ Digestive System
- ☐ Genitourinary Disorders
- ☐ Hematological Disorders
- ☐ Other_____
- ☐ Skin Disorders
- ☐ Endocrine Disorders
- ☐ Congenital Disorders
- ☐ Neurological Disorders
- ☐ Mental Disorders
- ☐ Cancer (Malignant Neoplastic Disease)
- ☐ Immune System Disorders

Does applicant currently have a diagnosis of any chronic disease?

- ☐ Yes
- ☐ No
- ☐ Unknown

If yes, select which chronic condition(s) below:

- ☐ Heart Disease
- ☐ Cancer
- ☐ Diabetes
- ☐ Other (*please provide below*): _____
- ☐ High Blood Pressure
- ☐ Obesity

Does applicant have a primary care provider?

☐ Yes
☐ No

Does applicant currently have a hearing aid?

☐ Yes
☐ No

If yes, month/year received: _____ Cost: _____
(*Attach Receipt*)

How did applicant learn about HAAP? _____

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

I have evaluated (*print applicant's name*): _____
and find that the applicant has a hearing loss that makes them a candidate for a hearing aid, and that no medical contra-indications for amplification exist.

Physician Name (*please print*): _____

Physician Address:_____

City: _____ State: _____ Zip: _____ Ward: _____

Physician Phone Number: _____ NPI #: _____

Signature of Physician: _____

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## Section V: Attestation

**I hereby certify that to the best of my knowledge the information in this application referring to my financial information and resources, family size, insurance is true and correct. I authorize DC Health to verify this information and I understand that any statement which is found to be false may result in my/ my dependent child's disqualification from receiving the reimbursement.**

**Applicant Name (*please print*)**: _____

**Applicant's Signature (*parent/guardian if under 18*)**: _____

**Date:** _____

## Section VI: Attachments

- ☐ Proof of Residency
- ☐ Proof of Income
- ☐ Receipt from hearing aid purchase
- ☐ Doctor's Note