Hearing Aid Coverage for Children Program Application

Complete this application to find out if you qualify for the Hearing Aid Coverage for Children Program (HACCP).

WHO CAN QUALIFY FOR HACCP?

TO QUALIFY FOR HACCP, INDIVIDUALS MUST MEET THE ELIGIBILITY RULES BELOW.

- Income eligibility above 266 percent of the Federal Poverty Level (FPL) (or 322 percent of the FPL if you live in Santa Clara, San Mateo, or San Francisco counties) up to and including 600 percent of the FPL.
- Be a California resident under 18 years of age.
- Not already have Medi-Cal, including presumptive eligibility.
- Have received a prescription from your health care provider for hearing aids or a referral for related services.
- Does not have California Children's Services (CCS) coverage for hearing aids and services.
- Does not have other health insurance or the health insurance does not cover hearing aids and services. If the health insurance does not cover hearing aids and services, a denial of coverage notice from the health insurance will need to be submitted.

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This application is used for internal purposes to assist applicants and retain for record keeping.

Section 1. Primary Contact

We need one adult in the family to contact if we need more information.

First Name | Middle Name | Last Name | Suffix

Home Address *(number & street)* | City and County | State | Zip Code

☐ If homeless, check the box and tell us where we can reach you in the mailing address field below.

Mailing Address *(if different than above)* | City and County | State | Zip Code

☐ If "Safe At Home" participant, check the box and answer the questions below.

1. What is your P.O. Box address, if known? _____
2. What is your Safe At Home Participant ID, if known? _____

Best contact phone number	Other phone number	Email

What language do you speak best?	What language do you read best?

Section 2. General Information

Answer each question for each child applying for coverage. Read down the column ▼ to tell us about children 1, 2, 3, and 4. Keep each child in the same column on all of the pages.

▼ Child 1	▼ Child 2	▼ Child 3	▼ Child 4
Tell us the name of each child in your home applying for coverage.			
First name	First name	First name	First name
Middle name	Middle name	Middle name	Middle name
Last name, Suffix	Last name, Suffix	Last name, Suffix	Last name, Suffix

Continue to answer general informational questions about Children 1, 2, 3, and 4. Keep each child in the same column on all of the pages.

What is this child's gender?			
☐ Female ☐ Male	☐ Female ☐ Male	☐ Female ☐ Male	☐ Female ☐ Male
What is this child's date of birth?			
Month / Day / Year	Month / Day / Year	Month / Day / Year	Month / Day / Year
What is the child's relationship to person in Section 1?			
☐ My child ☐ My stepchild ☐ Other	☐ My child ☐ My stepchild ☐ Other	☐ My child ☐ My stepchild ☐ Other	☐ My child ☐ My stepchild ☐ Other
Is this child pregnant?			
☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
☐ If *yes*, what is the due date?			
Month / Day / Year	Month / Day / Year	Month / Day / Year	Month / Day / Year
☐ If *yes*, how many babies are expected?			
How many? _____	How many? _____	How many? _____	How many? _____
Is this child currently living in California? If *yes*, what county is the child living in?			
Is Child 1 living in California? ☐ Yes ☐ No If *yes*, what county? _____	Is Child 2 living in California? ☐ Yes ☐ No If *yes*, what county? _____	Is Child 3 living in California? ☐ Yes ☐ No If *yes*, what county? _____	Is Child 4 living in California? ☐ Yes ☐ No If *yes*, what county? _____
Does this child currently have Medi-Cal?			
Does Child 1 currently have Medi-Cal? ☐ Yes ☐ No	Does Child 2 currently have Medi-Cal? ☐ Yes ☐ No	Does Child 3 currently have Medi-Cal? ☐ Yes ☐ No	Does Child 4 currently have Medi-Cal? ☐ Yes ☐ No
Does this child currently have Medicare?			
Does Child 1 currently have Medicare? ☐ Yes ☐ No	Does Child 2 currently have Medicare? ☐ Yes ☐ No	Does Child 3 currently have Medicare? ☐ Yes ☐ No	Does Child 4 currently have Medicare? ☐ Yes ☐ No

Continue to answer general informational questions about Children 1, 2, 3, and 4. Keep each child in the same column on all of the pages.

▼ Child 1	▼ Child 2	▼ Child 3	▼ Child 4
Does this child have a State of California Benefits Identification Card (BIC), also known as a Medi-Cal Card? If yes, what is the identification number on the card, *(if available)*?			
Child 1 ☐ Yes ☐ No If *yes*, identification number: _____	Child 2 ☐ Yes ☐ No If *yes*, identification number: _____	Child 3 ☐ Yes ☐ No If *yes*, identification number: _____	Child 4 ☐ Yes ☐ No If *yes*, identification number: _____
Does this child currently have health coverage through California Children's Services (CCS)?			
Child 1 ☐ Yes ☐ No If *yes*, does it cover hearing aids and services? ☐ Yes ☐ No	Child 2 ☐ Yes ☐ No If *yes*, does it cover hearing aids and services? ☐ Yes ☐ No	Child 3 ☐ Yes ☐ No If *yes*, does it cover hearing aids and services? ☐ Yes ☐ No	Child 4 ☐ Yes ☐ No If *yes*, does it cover hearing aids and services? ☐ Yes ☐ No
Does this child currently have private health insurance/coverage?			
Child 1 ☐ Yes ☐ No If *yes*: What is the insurer? _____ Plan/member ID? _____ Primary insured name? _____ Does the health insurance cover hearing aids and services? ☐ Yes ☐ No	Child 2 ☐ Yes ☐ No If *yes*: What is the insurer? _____ Plan/member ID? _____ Primary insured name? _____ Does the health insurance cover hearing aids and services? ☐ Yes ☐ No	Child 3 ☐ Yes ☐ No If *yes*: What is the insurer? _____ Plan/member ID? _____ Primary insured name? _____ Does the health insurance cover hearing aids and services? ☐ Yes ☐ No	Child 4 ☐ Yes ☐ No If *yes*: What is the insurer? _____ Plan/member ID? _____ Primary insured name? _____ Does the health insurance cover hearing aids and services? ☐ Yes ☐ No
Parent's information (Parent 1)			
Parent 1 name: _____ Last name: _____ Middle name: _____ Does the child live with parent 1? ☐ Yes ☐ No	Parent 1 name: _____ Last name: _____ Middle name: _____ Does the child live with parent 1? ☐ Yes ☐ No	Parent 1 name: _____ Last name: _____ Middle name: _____ Does the child live with parent 1? ☐ Yes ☐ No	Parent 1 name: _____ Last name: _____ Middle name: _____ Does the child live with parent 1? ☐ Yes ☐ No

Parent's information (Parent 2)			
Parent 2 name: _____ Last name: _____ Middle name: _____ Does the child live with parent 2? ☐ Yes ☐ No	Parent 2 name: _____ Last name: _____ Middle name: _____ Does the child live with parent 2? ☐ Yes ☐ No	Parent 2 name: _____ Last name: _____ Middle name: _____ Does the child live with parent 2? ☐ Yes ☐ No	Parent 2 name: _____ Last name: _____ Middle name: _____ Does the child live with parent 2? ☐ Yes ☐ No

Section 3. Tell us about your household size and income information.

Family size and income

List all family members who lives in the home. Include children under 21, stepparents, and the spouse of any teenager or pregnant individual who lives in the home. Do not list aunts, uncles, nieces, nephews or grandparents.

	Household Member 1	Household Member 2	Household Member 3	Household Member 4
Household Person Name	(Name, Last Name)	(Name, Last Name)	(Name, Last Name)	(Name, Last Name)
Relationship				
What is the person's relationship to person in Section 1?	☐ Child ☐ Stepchild ☐ Boyfriend ☐ Girlfriend ☐ Spouse ☐ Other	☐ Child ☐ Stepchild ☐ Boyfriend ☐ Girlfriend ☐ Spouse ☐ Other	☐ Child ☐ Stepchild ☐ Boyfriend ☐ Girlfriend ☐ Spouse ☐ Other	☐ Child ☐ Stepchild ☐ Boyfriend ☐ Girlfriend ☐ Spouse ☐ Other
Current Income				
Is this household member currently employed?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Employer Name				
How often is income received? (weekly, bi-weekly, twice a month, monthly, yearly)				
How much income is received? (total gross income)				

Self-Employment Income				
Is this household member currently Self-employed?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Type of Self-employed business?				
Net Self-employment Income Amount				
How often is income received? (weekly, bi-weekly, twice a month, monthly, yearly)				
Other income not listed above				
Does this household member have other income? (income from something other than your job)	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Type of Income				
Gross Income Amount				
How often is income received? (weekly, bi-weekly, twice a month, monthly, yearly)				

****If more than 5 people in household, add names on separate sheet of paper****

Section 4. Sign the form.

By signing, I declare that what I say below is true and correct.

- I have read and understand this HACCP Application.
- The information I provided is true, correct, and complete.
- I understand that I must submit the corresponding prescription or referral from my health care provider and a denial of coverage from my health insurance in order to be eligible for coverage.

Signature of parent/guardian/ emancipated minor	**Relationship to the child(ren) applying** *(if applicable)*	**Date** (mm/dd/yyyy)

An individual has a right to review records containing his/her personal information. The official entity responsible for keeping the information contained in this application is the California Department of Health Care Services. This information may be shared with the County Department of Social Services in the county in which the individual resides.

HERE IS HOW TO APPLY:

1 Fill out the application.

If you do not understand a question, or do not have any of the documents, call: **1-833-956-2878**. Or, look for the information you need on pages 2-6.

2 Send us copies of income documents.

(You may be able to use other documents not listed here)

☐ **One document for each person living in the home who has a job:**

- A recent pay stub (from less than 45 days ago), ***or***
- A signed, dated statement from your employer showing your gross income and how often you are paid, ***or***
- Last year's federal income tax return.

☐ **One document for each person living in the home who is self employed:**

- Last year's federal income tax form with Schedules C, C-EZ, or F, ***or***
- A signed, itemized profit and loss statement for the last 3 months.

☐ **If you have income from Disability, Pensions, Retirement, Social Security, Veteran's Benefits, Worker's Compensation, or Unemployment, send a copy of:**

- The award letter, check, ***or*** bank statement showing direct deposit for the most recent payment.

IF YOU QUALIFY FOR HACCP - WHAT HAPPENS NEXT?

- On the day you are approved for HACCP, we will send you a HACCP Program ID card to use immediately to receive covered HACCP service benefits, such as prescribed hearing aids or related services and supplies.
- When you turn 18, you are no longer eligible for HACCP coverage.

INDIVIDUALS CAN APPLY FOR MEDI-CAL AND OTHER HEALTH COVERAGE

You may qualify for free or low-cost health coverage through Medi-Cal. Or, you may qualify for financial help that can lower monthly costs (premiums) and co-payments for health plans through Covered California.

You can apply or get help in any of the following ways:

- **Online:** https://www.coveredca.com/
- **By phone: English:** (800) 300-1506 | TTY: (888) 889-4500 or **Español:** (800) 300-0213

For additional information on applying for California Children's Services, please refer to: https://www.dhcs.ca.gov/Services/CCS.

IF YOU DO NOT QUALIFY FOR HACCP - WHAT HAPPENS NEXT?

If you do not qualify for HACCP, you will receive a denial letter that will explain how you can appeal the eligibility decision, BUT you can still apply for Medi-Cal or other health insurance by completing the insurance affordability application. If there are errors or corrections needed due to system issues, or **if you have any questions, please call the Hearing Aid Coverage for Children Program at 1-833-956-2878**, Monday through Friday, 8:00 a.m. to 7:00 p.m. and Saturday 8:00 a.m. to 12:00 p.m.

WHERE TO SEND YOUR APPLICATION

You can send the application by mail to:

Hearing Aid Coverage for Children Program
PO Box 138000
Sacramento, CA 95813

Or fax to: 833-774-2227