Hearing Aid Coverage for Children Program
Annual Eligibility Review Application

Complete this Annual Eligibility Review (AER) Application to find out if you still qualify for the Department of Health Care Services' (DHCS') Hearing Aid Coverage for Children Program (HACCP).

This form is used for internal purposes to assist members and retained for record keeping.

Family Member Number: ________________ *or* HACCP number(s): ________________________

1. Primary Contact

List one adult to contact if DHCS needs more information. This can be:

- Member (if at least 18 years of age or an emancipated minor)
- Member's parent or guardian (if the member is an unemancipated minor)
- Authorized representative (a person you allow to see your application and talk to DHCS on your behalf about your eligibility and enrollment)

Fill out Option A or B, below. A signature is required for Option B.

☐ **A) Primary contact is the member or their parent or guardian:**

Name of primary contact *(first name, middle name, last name)*

☐ **B) Primary contact is an authorized representative:**

Name of authorized representative *(first name, middle name, last name)*

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

By signing, you are allowing your authorized representative to sign your AER Application, obtain official information about your application, and act on your behalf for all future HACCP matters with DHCS. You or your authorized representative may change or cancel this authorization at any time.

Signature of member *(if at least 18 years of age or an emancipated minor)* **or parent or guardian** *(if unemancipated minor)*	**Relationship to member(s)** *(self, parent, or guardian)*	**Date**

2. Have there been any changes to your contact information? ☐ Yes ☐ No

If yes, fill out the applicable field(s) below.

Home Address *(number and street)*	Mailing Address *(If different from Home Address)*
City County State Zip Code	City County State Zip Code
Best contact phone number	Email

3. HACCP Member(s)

Update the information below for each child or youth under age 21 enrolled in HACCP. (If more than two HACCP members live in the household, list additional members on a separate sheet of paper.)

Member 1: Name *(first name, middle name, last name)*

____

Does this member currently have coverage through the Medi-Cal program? ☐ Yes ☐ No

Does this member currently have coverage for hearing aids through the California Children's Services (CCS) program? ☐ Yes ☐ No

Does this member currently have coverage through private health insurance? ☐ Yes ☐ No
If yes, include a denial of coverage notice or current year's Evidence of Coverage (EOC).

Who is the insurer? ______________________ Plan/Member ID? ___________________________

Primary Insured Name? __________________ Does the plan cover hearing aids? ☐ Yes ☐ No

Member 2: Name *(first name, middle name, last name)*

____

Does this member currently have coverage through the Medi-Cal program? ☐ Yes ☐ No

Does this member currently have coverage for hearing aids through the CCS program?
☐ Yes ☐ No

Does this member currently have coverage through private health insurance? ☐ Yes ☐ No
If yes, include a denial of coverage notice or current year's EOC.

Who is the insurer? ______________________ Plan/Member ID? __________________________

Primary Insured Name? __________________ Does the plan cover hearing aids? ☐ Yes ☐ No

4. Have there been any changes to the family members living in the home? ☐ Yes ☐ No

If yes, list any additions, removals, or updates for children or youth under age 21, parents, stepparents, and the spouse of youth under age 21, or pregnant individuals who live in the home. Do not list aunts, uncles, nieces, nephews, or grandparents.

Change	Household Member's Name *(first, middle, last)*	Date of Birth	Relationship to Member(s)	Is this person currently employed?
☐ Add ☐ Remove ☐ Update			☐ Parent ☐ Stepparent ☐ Child ☐ Stepchild ☐ Spouse ☐ Other __________	☐ Yes – *Please include income details below, in Section 5.* ☐ No
☐ Add ☐ Remove ☐ Update			☐ Parent ☐ Stepparent ☐ Child ☐ Stepchild ☐ Spouse ☐ Other __________	☐ Yes – *Please include income details below, in Section 5.* ☐ No

5. Income

Please provide current information regarding household income and submit recent income documentation for all household members reporting income.

Name of household member with income	What is the source of this income? *(Example: Earnings from job, self-employed, other)*	Gross Income Amount *(If self-employed, use net income)*	How often is the income received?
			☐ Weekly ☐ Bi-weekly ☐ Monthly ☐ Semi-monthly ☐ Yearly
			☐ Weekly ☐ Bi-weekly ☐ Monthly ☐ Semi-monthly ☐ Yearly
			☐ Weekly ☐ Bi-weekly ☐ Monthly ☐ Semi-monthly ☐ Yearly
			☐ Weekly ☐ Bi-weekly ☐ Monthly ☐ Semi-monthly ☐ Yearly

6. Please read and sign this form.

Privacy Notice

This form is used to determine HACCP member eligibility to extend or renew enrollment. The personal and medical information collected on and for this form is private and confidential, requested by DHCS to identify you and the other people on this application and to administer our programs. Any personal and health information collected on this form by DHCS is subject to limitations in the Information Practices Act (IPA), Health Insurance Portability and Accountability Act (HIPAA), and other state policy. DHCS will not use or share your information unless authorized by you, or by the individual to whom it pertains, in writing or as authorized by law. You must provide all information requested on this form and should not provide personal information that is not requested. If you do not provide all information requested, we cannot extend or renew your enrollment in HACCP. DHCS may share or provide any of the information provided on or for this form to other state, federal, and local agencies (for example, the county Department of Social Services in the county in which the individual resides), contractors, and programs only to enroll you in a program or to administer programs; or as required by law. In most cases, the individual(s) to whom this information pertains has the right to access it. For more information or to obtain access to records containing your personal information maintained by DHCS, contact HACCP.

DHCS is authorized to collect this information pursuant to the Budget Act of 2022 [Assembly Bill 179 (Chapter 249, Statutes of 2022)]. DHCS is also authorized to collect personal and health information for the administration of HACCP and the Medi-Cal program. For more information about DHCS' privacy practices, please visit https://www.dhcs.ca.gov/formsandpubs/laws/priv/Documents/Notice-of-Privacy-Practices-English.pdf and https://www.dhcs.ca.gov/Pages/Privacy.aspx.

If you wish to obtain a paper copy of DHCS' privacy policy and practices, or wish to file a complaint, you may contact DHCS' Data Privacy Unit by mail, email, or telephone:

Privacy Office
c/o: Data Privacy Unit
Department of Health Care Services
P.O. Box 997413, MS 4722
Sacramento, CA 95899-7413

Email: incidents@dhcs.ca.gov

Telephone: (916) 445-4646

The privacy notice provided here is required by California Civil Code 1798.17.

Declaration and signature *This is required.*

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

- I have read and understand this HACCP AER Application.
- The information I provided is true, correct, and complete.
- I understand that I must submit the applicable recent income documentation and health plan documents in order to renew my coverage.

Signature of member *(if at least 18 years of age or an emancipated minor)* **or parent or guardian** *(if unemancipated minor)* **or authorized representative**	**Relationship to member(s)** *(self, parent or guardian, or authorized representative)*	**Date**