OCEAN STATE CENTER FOR INDEPENDENT LIVING
1944 Warwick Ave, Warwick, RI 02889 ~ 175 Main St, Pawtucket, RI 02860
Phone: 401-738-1013 ~ VP: 244-7792 ~ Website: oscil.org

To Whom It May Concern,

We received your referral. Thank you for your interest in our programs and services. The Ocean State Center for Independent Living (OSCIL) works collaboratively with the University of Rhode Island to provide hearing aids at reduced cost for those in need. This program is called, The Gift of Hearing Collaborative. Enclosed you will find the pre-visit packet. Please fill this out completely and mail it back to us. When you are done filling out the application, please review to ensure that you have filled out each of the pages. All personal information you provide is considered confidential and will only be shared with those providing you with services. Upon receiving your completed packet an OSCIL staff member will be contacting you to set up an appointment for your Independent Living Assessment and to review of your eligibility. We will then assist you with the process to obtain your hearing aids.

OSCIL makes every effort to work as quickly and efficiently as we can. **Please be sure that your pre-visit packet is completed prior to submitting it to us, as incomplete applications may cause a delay in services.** If you have any questions about the program or the necessary documents required, please call us at our office (401)738-1013, we would be more than happy to assist you. Thank you for your time and consideration.

Sincerely,
OSCIL Staff
Gift of Hearing Collaborative

The Gift of Hearing Collaborative Application

NAME: _____

STREET ADDRESS_____

CITY/ STATE/ ZIP_____

TELEPHONE#_____

DATE OF BIRTH _____ GENDER_____

NAME AND PHONE NUMBER OF PERSON WHO PROVIDES YOUR TRANSPORTATION

_____

ADDITIONAL COMMENTS

_____

_____

_____

_____

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Here are the documents needed for the Gift of Hearing (GOH) Program. Please check off items to ensure that ALL copies of documents are included with your application.

____ Photo ID and medical insurance cards (that are active.)

____ Social Security Award letter (if married, need spouse's letter also) and /or statements from any other monthly income.

____ One month of bank statements from ALL accounts (must be within last 90 days)

____ Federal tax return from last year (If applicable)

____ Hearing Test within last the 12 months, if you do not have a hearing test within the last 12 months, please contact OSCIL. Some insurances are accepted at URI for a hearing test.

____ Signed Authorization For Disclosure of Confidential Information.
URI (included in application packet)

____ Signed Authorization For Disclosure of Confidential Information.
PRIMARY CARE PHYSICAN- PLEASE FILL IN NAME AND PHONE NUMBER (included in application packet)

____ Send certificate of medical necessity to primary care physician for signature. PCP to fax back to OSCIL.

Once you have completed your pre-visit application, please send it along with the documents in the enclosed self-addressed envelope to:

OSCIL
ATTN: GIFT OF HEARING
1944 Warwick Ave
Warwick RI 02889

If you have any questions, regarding the process or need assistance, please call us at 401-738-1013. Our staff would be happy to assist you.

OSCIL
oscil.org

OCEAN STATE CENTER FOR INDEPENDENT LIVING

1944 WARWICK AVENUE WARWICK, RI 02889 401-738-1013 (V)
401-738-1015 (TTY) 401-738-1083 (FAX) 1-866-857-1161 (Toll Free)

AUTHORIZATION FOR DISCLOSURE/USE OF CONFIDENTIAL INFORMATION

In accordance with the State and Federal Regulations, this is to authorize the ***Ocean State Center for Independent Living (OSCIL)*** to: Obtain from: ☐ Release to: ☐

PCP

Hospital, Doctor, Agency, Institution or Company

Address City State Zip

Information: Medical ☐ Psychological ☐ Social ☐ Financial ☐
Vocational/Education ☐ Other (Specify) _____

Name of person about whom information is being requested Date of Birth

Address City State Zip

Brief statement of the need for, and the proposed uses of, the information:

Information related to hearing to aid consumer in obtaining hearing aids

Brief statement indicating the extent of the information to be released:

Any related to above

I understand that I may revoke this authorization in writing at any time to OSCIL and that, if I do, OSCIL may condition my access to services on my decision to revoke. In addition, any information disclosed to OSCIL before I revoked this authorization, as well as any information disclosed to other parties by this authorization, may no longer be protected by the Health Insurance Portability and Accountability Act (HIPAA) Privacy Rule [45 CFR Part 164], and the Privacy Act of 1974 [5 USC 552a]. If this authorization has not been revoked, it will terminate one year from the date of my signature unless I have specified a different expiration date or expiration event on the line below. Any information released or received as a result of this consent shall not be further relayed to any person or organization outside OSCIL without additional written consent from me.

(Enter if different from one year after the date below)

Signature: _____ Date: _____

If the person is a minor, or unable to sign, this authorization must be signed by a parent, legal guardian or next-of-kin. The mark must be witnessed.

Witness: _____ Relationship: _____

Signature/Title of Agency Rep. Telephone

3/2009

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To Whom It May Concern,

The following Certificate of Medical Necessity may be filled out by an audiologist OR primary care doctor. It is to certify that the patient named would benefit from hearing aids if an otological exam were to demonstrate hearing loss. This does not need to be signed by the doctor that preforms said exam. It is just to certify that if such an exam is preformed, that the patient would benefit from the use of durable medical equipment such as a hearing aid.

This form is needed for OSCIL to be able to offer the patient low to no cost hearing aids. If you have any questions about this form, you may call the Gift of Hearing program at 401-738-1013 or the URI Speech and Hearing Center at 401-874-5969.

Sincerely,

Ocean State Center for Independent Living
Gift of Hearing Program

Ocean State Center for Independent Living
"People Helping People Achieve Independence"
SINCE 1988

STATE OF RHODE ISLAND
EXECUTIVE OFFICE OF HEALTH AND HUMAN SERVICES
MEDICAID PROGRAM

CERTIFICATE OF MEDICAL NECESSITY
HEARING AIDS

NAME: _____ MID: _____

DOB: _____

Does beneficiary own any other hearing aids?_____Yes_____No If yes, how many?_____

If yes, what is the age of the hearing aid(s)? Hearing Aid #1_____Hearing Aid #2 _____

Were the hearing aid(s) purchased through Medicaid?_____Yes _____No

Describe the hearing aid(s) _____

_____

Why is the beneficiary requesting new hearing aid(s)? _____

_____

This is to certify that an otological examination of the above-named beneficiary demonstrates a hearing impairment of such a nature as to indicate the need for a hearing aid instrument or hearing prosthetic device.

Prescriber Signature:_____MD/DO

Prescriber Name: _____
Please print or type

NPI: _____

Date: _____

Proof of medical necessity is valid for 12 months from the date of issue.

Please complete and fax to OSCIL ATTN: GOH PROGRAM 401-738-1083
If you have any questions please call 401-738-1013