PACIFIC BLUE CROSS®

DO NOT WRITE IN THIS SPACE

BRITISH COLUMBIA | Ministry of Social Development and Poverty Reduction

ALTERNATIVE HEARING ASSISTANCE SUPPLEMENT OR CLIENT CHANGE OF ADDRESS

PO Box 65339, Vancouver, BC V5N 5P3 | Drop it off: 4250 Canada Way, Burnaby, BC | Ph: 604 419-2780 | Toll-free: 1 800 665-1297 | pac.bluecross.ca

Please select: ☐ APPLICATION REQUEST ☐ ADDRESS CHANGE ONLY — Please only complete Part 1 and sign under Part 2

Please keep all original documents for your records. The purpose of this form is to collect the information necessary to determine eligibility for the Alternative Hearing Assistance Supplement or for the client to update their address.

For eligibility requirements, please see the back of this form.

Note: an incomplete application will delay processing.

PART 1 — MEMBER INFORMATION

First name	Last name	Daytime phone number (10 digits)	Birthdate (mm-dd-yyyy)

Street address	City	Province	Postal code

If applicant is under the age of 19 years: Parent/Guardian First/Last name	Personal Health Number (PHN)

PART 2 — APPLICATION ACKNOWLEDGEMENT, HEARING INSTRUMENT INFORMATION AND CONSENT

1. Have you received a hearing instrument (includes cochlear implants) in the past 36 months? ☐ Yes ☐ No	If yes, when? (mm-dd-yyyy)

2. If the answer to question 1 is "yes", did the Ministry of Social Development and Poverty Reduction or Healthy Kids Program provide or pay for the hearing instrument? ☐ Yes ☐ No

I declare that the information provided on this form is true and complete. I consent to the audiologist or hearing instrument practitioner (identified in Part 4 of this application) sharing and providing clarification on the medical information requested in this application form with the ministry for the purposes of determining eligibility for this supplement. I consent to Pacific Blue Cross acting on my behalf with regards to the items/services indicated on this form for auditing purposes. **If there are any changes to the information above, I will notify Pacific Blue Cross by submitting this form.**

Applicant or parent/guardian signature **X**	Full name (print)	Title	Date (mm-dd-yyyy)

PART 3 — HEARING ASSESSMENT INFORMATION (Completed by an Audiologist or Hearing Instrument Practitioner)

1. As supported by the attached audiological assessment, the client has "permanent profound hearing loss of 91 decibels or greater in both ears, across all frequencies": ☐ Yes ☐ No

2. In your opinion, would the client significantly benefit from a hearing instrument for the purpose of speech comprehension? ☐ Yes ☐ No
   Please explain:

3. If the client received a hearing instrument in the past 36 months (as per Part 2), has the degree of hearing loss experienced by the client changed since the date the hearing instrument was provided? ☐ Yes ☐ No ☐ Don't know
   If the answer to question 3 is "yes," please explain this change:

Please attach a copy of a recent audiological assessment (completed within the previous 12 months).

PART 4 — PROVIDER INFORMATION

Practitioner name	PBC provider number	PBC practitioner number

Name and Address of Employment	Daytime phone number (10 digits)

Type of Employment	Please explain
☐ Self-employed/ private practice ☐ Health Authority ☐ Other	

I certify I have completed an audiological assessment of the applicant identified in part 1 and this form, and the attached documents contain my findings and considered opinion at this time.

Signature of practitioner	Full name (print)	Title	Date (mm-dd-yyyy)
X			

The personal information requested on this form is collected by the Ministry of Social Development and Poverty Reduction pursuant to section 26(c) of the Freedom of Information and Protection of Privacy Act for the purpose of administering the Employment and Assistance Act and the Employment and Assistance for Persons with Disabilities Act. If you have any questions about the collection, use or disclosure of this information, please contact the Ministry of Social Development and Poverty Reduction at 1 866 866-0800.

Eligibility: The Alternative Hearing Assistance Supplement may be provided to an applicant who is eligible for general health supplements under the Employment and Assistance Regulation or the Employment and Assistance for Persons with Disabilities Regulation, or the Healthy Kids Program.

In addition, the ministry must be satisfied that the applicant has permanent profound hearing loss in both ears and cannot significantly benefit from a hearing instrument for the purpose of speech comprehension. "Profound hearing loss" means a hearing loss of 91 decibels or greater across all frequencies tested in an audiological assessment.

The applicant may not be eligible for this supplement if they have received a hearing instrument from any source in the previous 36 months, unless the person has developed permanent profound hearing loss in both ears since receiving the hearing instrument.

Full details on eligibility criteria can be found on the ministry's Policy and Procedure Manual at: https://www2.gov.bc.ca/gov/content/governments/policies-for-government/bcea-policy-and-procedure-manual/health-supplements-and-programs/alternative-hearing-assistance-supplement.

**Pacific Blue Cross is a registered trade-mark of the Canadian Association of Blue Cross Plans (CABCP) and registered trade-name of PBC Health Benefits Society (PBC), an independent licensee of CABCP. Life, Disability, Accidental Death & Dismemberment and Critical Illness insurance is underwritten by Blue Cross Life Insurance Company of Canada. †Blue Shield is a registered trade-mark of Blue Cross Blue Shield Association. All rights reserved.