

# Hearts for Hearing

3525 NW 56th Street, Suite A-150  
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## FINANCIAL ASSISTANCE APPLICATION

Date of Application \_\_\_\_\_ Referral Source \_\_\_\_\_

Patient Name \_\_\_\_\_ Date of Birth \_\_\_\_\_ Age \_\_\_\_\_

Name of Responsible Party \_\_\_\_\_ Relationship to Patient \_\_\_\_\_

Address \_\_\_\_\_

Phone \_\_\_\_\_ Street \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip code \_\_\_\_\_ County \_\_\_\_\_  
Cell Phone \_\_\_\_\_

Funding is being requested for

\_\_\_\_Hearing Aids \_\_\_\_Earmolds \_\_\_\_Audiological Services \_\_\_\_Auditory-Verbal Therapy \_\_\_\_Education

Please attach copies of your income tax returns for the past two years and recent paycheck stubs, **551**, SSD etc., verifying income and submit this information **no later than 2 weeks prior to your first appointment** for processing. If you have not filed current year taxes upon completion of this form, please send a copy of your current W-2, and include a copy of your last two years tax return.

1. Annual adjusted gross income: Last Tax Return \_\_\_\_\_ Prior Year \$ \_\_\_\_\_

2. Current income earned from employment:

Parent/Guardian (1) Occupation \_\_\_\_\_ \$ \_\_\_\_\_ Hour/Year

Parent/Guardian (2) Occupation \_\_\_\_\_ \$ \_\_\_\_\_ Hour/Year

If unemployed, monthly unemployment compensation amount \$ \_\_\_\_\_

How long unemployed \_\_\_\_\_ Unemployment remaining \$ \_\_\_\_\_

3. Other assets: Businesses, Cash, savings, stocks, bonds, CD's, second home, recreational vehicles, etc. (exclude retirement funds, i.e. IRA):

\_\_\_\_\_ \$ \_\_\_\_\_  
\_\_\_\_\_ \$ \_\_\_\_\_  
\_\_\_\_\_ \$ \_\_\_\_\_  
\_\_\_\_\_ \$ \_\_\_\_\_

4. Other income:

Please specify source \_\_\_\_\_ \$ \_\_\_\_\_

5. Total number in household \_\_\_\_\_

Parent's current marital status \_\_\_\_single \_\_\_\_married \_\_\_\_separated \_\_\_\_divorced \_\_\_\_widowed

Parent's highest level of education  
\_\_\_\_High school \_\_\_\_Associate's degree  
\_\_\_\_GED \_\_\_\_Bachelor's degree  
\_\_\_\_Trade school \_\_\_\_Master's degree  
\_\_\_\_Community college \_\_\_\_Doctorate

List all persons living in the home with applicant (Applicant's name first)

1. \_\_\_\_\_ Relationship \_\_\_\_\_  
2. \_\_\_\_\_ Relationship \_\_\_\_\_  
3. \_\_\_\_\_ Relationship \_\_\_\_\_  
4. \_\_\_\_\_ Relationship \_\_\_\_\_  
5. \_\_\_\_\_ Relationship \_\_\_\_\_  
6. \_\_\_\_\_ Relationship \_\_\_\_\_

(Continued on backside)



### Monthly Expenses

Home:  Own Mortgage payment \$\_\_\_\_\_ Property taxes/monthly \$\_\_\_\_\_ Monthly payment \$\_\_\_\_\_

Rent Rent paid to \_\_\_\_\_ Monthly payment \$\_\_\_\_\_

Utilities/month \$\_\_\_\_\_

### Medical Bills

Monthly medical costs (include explanation and name of doctor/hospital/clinic)

\_\_\_\_\_ \$ \_\_\_\_\_

\_\_\_\_\_ \$ \_\_\_\_\_

\_\_\_\_\_ \$ \_\_\_\_\_

\_\_\_\_\_ \$ \_\_\_\_\_

Total monthly expenses \$\_\_\_\_\_

### Insurance Coverage

(Please submit a copy of the front and back of each insurance card)

#### PRIMARY Insurance

Insurance company name \_\_\_\_\_

Subscriber's name \_\_\_\_\_

Subscribers ID# \_\_\_\_\_

Group or policy # \_\_\_\_\_

Subscriber's date of birth \_\_\_\_\_

Relationship to patient \_\_\_\_\_

#### SECONDARY Insurance

Insurance company name \_\_\_\_\_

Subscriber's name \_\_\_\_\_

Subscribers ID# \_\_\_\_\_

Group or policy # \_\_\_\_\_

Subscriber's date of birth \_\_\_\_\_

Relationship to patient \_\_\_\_\_

In order to process this proposed application, the following items must be submitted with this signed application:

1. Most recent Federal income tax returns
2. Current picture of your child
3. \$25 Non-refundable processing Fee

Certification: I (we) certify that all the information on this form is true and complete to the best of my (our) knowledge. If asked by any authorized official of Hearts for Hearing, I (we) agree to give documentation for information given on this form. I (we) realize that failure to comply with a request for further information may prevent the applicant from receiving any aid. I (we) hereby authorize the Financial Assistance committee or any other investigative agency employed by Hearts for Hearing to investigate the references herein listed or statements of other data obtained from me (us) or from any other person pertaining to my (our) credit and financial responsibility. I (we) understand that if I (we) am/are approved for a discount I (we) may be required to provide explanation of benefits from our insurance carrier for our appointments.

Applicant's signature \_\_\_\_\_ Date \_\_\_\_\_

### For internal use only

|                                     |                            |
|-------------------------------------|----------------------------|
| Date                                | Date                       |
| Application Received _____          | Application Approved _____ |
| Initials _____                      | Initials _____             |
| Date                                |                            |
| Hearing Aids Dispensed (Type) _____ |                            |