

Hearts for Hearing

3525 NW 56th Street, Suite A-150
Oklahoma City, OK 73112
405.548.4300 – Fax: 405.548.4350



FINANCIAL ASSISTANCE APPLICATION

Date of Application _____ Referral Source _____

Patient Name _____ Date of Birth _____ Age _____

Name of Responsible Party _____ Relationship to Patient _____

Address _____
Street City State Zip code County

Phone _____ Cell Phone _____

Email Address: _____

Funding is being requested for

____Hearing Aids ____Earmolds ____Audiological Services ____Auditory-Verbal Therapy ____Education

Please attach a copy of your income tax return for the past year indicating your adjusted gross income. The completed application must be processed and approved prior to the assignment of financial assistance for services rendered.

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.

I am (we are) completing this application due to the immediate overwhelming medical expenses secondary to my (our) child's hearing loss.

Applicant's signature_____ Date_____