Dear Applicant,

Thank you for showing interest in the Help Us Hear Program established by the Ear Research Foundation. ***It is our belief that the gift of hearing should not be limited to only those who can afford it.*** Our goal is to educate the public on the incidence and impact of hearing loss, treatment options available, and to provide hearing aid assistance to eligible candidates.

Eligibility for Help Us Hear is based on hearing loss, income and assets of candidates who permanently reside in the U.S. Consideration is only for individuals with **no other resources** available to them, including family support, insurance, state Medicaid programs, vocational rehabilitation, VA, church groups and state or local programs. If you have funds available in money market accounts, mutual funds, 401(k) plans, IRAs, CDs (certificates of deposit), checking/savings accounts, stocks, bonds, T-bills or property, this may not be the program for you. These are all considered when determining eligibility.

As the Ear Research Foundation has limited funds available, please follow the recommended procedure ***prior*** to applying.

- Contact the applicant's Health Care Provider and Insurance Company to see if the policy covers testing and/or hearing aids. Please advise as to the extent of coverage.
- Working Age Patients – Contact the local Vocational Rehab for assistance first.
- Veterans – Contact the local VA office to get assistance first.

If the above resources have been attempted and denied, please complete the attached application and return it to the address noted below. **Incomplete applications *will not* be considered.** Processing may take up to 3 weeks *after* being received. Selected applicants will be notified by telephone. Non-qualifying applicants will be notified by mail.

Processing your application.

1. The recipient is required to have a **hearing test** within one year prior to applying for this service. This hearing test can be administered by the Silverstein Institute or another ENT office. **A copy of the hearing test must be provided before further consideration.**
2. The HUH committee will review the hearing test.
3. *If it is determined that a hearing aid is necessary*, an appointment with one of our Audiologists will be scheduled and the patient will be fitted with an appropriate hearing aid (*from select models*).
4. An appointment will then be made to pick up the hearing aid (*which includes one month supply of batteries and one additional follow-up visit for adjustments*). Should it be determined that surgical reconstructions and/or implants are necessary, options will be discussed at that time. Eligibility for surgical reconstructions or implants is determined ONLY after all hearing aid tests and possibilities have been explored.

The application fee of $100 (payable by cash, check or credit card) will be processed ONLY after notification of selection. **If the patient is not selected**, the credit card will **NOT** be charged and checks will be voided. Selected patients are eligible for a **single** hearing aid after the appropriate testing has been done. **The cost of testing and/or office visits is NOT covered by the Help Us Hear program and will be charged to the patient's insurance.** If the patient does not have insurance, options including sliding scale cost and payment plans are available.

In addition to completing this application, the candidate ***must*** also include **proof of income and a brief letter** describing the needs and how the program will be beneficial. Applications can be submitted by using one of the following methods:

1. **Mail** the application along with proof of income, letter of need and check or credit card payment to:

   Ear Research Foundation
   HUH Program-Melissa Lane
   1901 Floyd Street
   Sarasota, FL 34232

2. **Electronically -** print, scan & email the application, proof of income, letter of need and credit card information as an attachment to msmith@earsinus.com

Please understand that although assistance is available, it can be time-consuming and we often have a waiting list. Applications are reviewed in the order in which they are received and appointments are scheduled based on availability. Please contact Melissa Lane at (941) 365-0367 questions regarding this matter or if further assistance is needed.

Sincerely,

Melissa M. Lane
Melissa M. Lane
Executive Director

Income Guidelines

All income figures are NET (the amount you actually receive in your check(s) (regardless of source).

2018 POVERTY LEVEL GUIDELINES	
PERSONS IN FAMILY/HOUSEHOLD	**YEARLY INCOME**
1	$16,996
2	$23,044
3	$29,092
4	$35,140
5	$41,188
6	$47,236
7	$53,284
8	$59,332

For families/households with more than 8 persons,
add $4,180 for each additional person.

Eligibility Determination

In determining eligibility, Help Us Hear considers all available household funds and assets as well as hearing loss.

1. **The household** is defined as those living together or dependent on each other.
2. **Net Monthly or Annual Income** is based on all occupants of the "Household" who have income.

   – Social Security and SSI – Public Assistance – AFDC – Wages
   – VA Pension – Alimony – Disability – Old Age Pension
   – Interest from Stocks, IRAs, 401(k) – Child Support – Welfare – Work Pension

3. **Assets** (including but not limited to):

   – Checking Account – Annuities – Savings – Property
   – Money Market Accounts – IRA/401(k) – CDs – Home Equity Loan
   – Reverse Mortgage – Burial Accounts – Stocks/Bonds

Ear Research Foundation
Application for Help Us Hear Program

GENERAL INFORMATION (Please print clearly)

Date: _____ Email:_____

Applicant Name: First_____ Middle _____ Last _____

Date of Birth: _____ Age: ____ Social Security Number: _____ Gender: M / F

Marital Status: ___ Married ___ Single ___ Divorced ___ Widowed ___ Separated

Number in Household: ____ (Defined as all those living together or dependent on each other.)

Insurance: Name of Insurance: _____Insured name_____ Policy #_____

☐ I can provide a recent hearing test. ☐ Silverstein Institute ☐ Other ENT hearing test

☐ I would like to schedule a hearing test with Silverstein Institute. ☐ Insurance or ☐ self-pay

Mailing Address: Street _____Apt # _____

City _____ State _____ Zip _____

Home Phone: _____ Alternate Phone: _____

Person, if other than applicant, completing this form. If patient is a minor, list parent/guardian's Information:

Name: _____ Relationship to Applicant: _____

Phone: _____ Email: _____

ADDITIONAL INFORMATION

Do you have any of the items listed below? Unanswered questions will delay the process.

	YES	NO	
Checking Account	☐	☐	If yes, provide statements for the last 6 months.
Savings Account	☐	☐	If yes, provide your most recent statement.
Credit Card	☐	☐	If yes, provide your most recent statement.
CD(s)	☐	☐	If yes, provide your most recent statement.
Stocks/Bonds	☐	☐	If yes, provide your most recent statement
Annuity	☐	☐	If yes, provide your most recent statement.
IRA/401(k)	☐	☐	If yes, provide your most recent statement.
Money Market Acct	☐	☐	If yes, provide your most recent statement

Do you own your home? ☐ Yes ☐ No
If yes, provide the amount of your property taxes? $_____ Send current statement.

Do you live in subsidized housing? ☐ Yes ☐ No
If yes, provide documentation of approval notice and rent amount. $ _____

Are you a Medicaid recipient? ☐ Yes ☐ No
Are you a Medicare recipient? ☐ Yes ☐ No

Do you have medical insurance? ☐ Yes ☐ No
If yes, provide the name of your medical insurance company? _____
Group Number: _____

HOUSEHOLD INFORMATION

Applicant ☐ Employed ☐ Retired ☐ Other _____

Name of applicant's current employer: _____

Telephone: _____ Length of employment: _____ (Years/Months) Amount of Income $: _____

Spouse ☐ Employed ☐ Retired ☐ Other _____

Name of spouse's current employer: _____

Telephone: _____ Length of employment: _____ (Years/Months) Amount of Income $: _____

Number of other individuals in household: _____.

Please list the names of **all** individuals living in your household.

Name	Age	Employment Status	Amount of Income
_____	_____	☐ Employed ☐ Retired ☐ Other	_$_____
_____	_____	☐ Employed ☐ Retired ☐ Other	_$_____
_____	_____	☐ Employed ☐ Retired ☐ Other	_$_____
_____	_____	☐ Employed ☐ Retired ☐ Other	_$_____

RELEASE OF INFORMATION

I understand that the information I submit to the Ear Research Foundation for the Help Us Hear Program concerning my annual income, family size, family resources, insurance, medical history and all financial information is subject to verification by the Ear Research Foundation. This verification will be done by telephone, letter, email or credit check. I understand that if I knowingly omit or submit false information, I will be denied consideration for assistance at any point during the process. I understand that the Foundation reserves the right to cancel my assistance and collect full fees for services in the event of fraudulent financial status while involved with any of the programs.

Applicant Name: _____

Applicant Signature: _____

If Minor, Parent/Guardian Signature: _____

RELEASE OF INFORMATION FOR PATIENT CARE, EDUCATIONAL, PROMOTIONAL AND FUND-RAISING PURPOSES

I understand that release of information regarding my care and treatment may be used for patient care, educational, promotional, public relations and/or fund-raising purposes. I authorize the Ear Research Foundation and/or staff for permission to use any and all records of my care and treatment, which may be used for these purposes.

I further understand that photographs, movies or videotapes may be taken of my care and treatment and authorize the use of said photographs, movies or videotapes for the purposes of patient care, education, promotional materials, public relations, publicity and/or fund-raising.

I hereby authorize the Ear Research Foundation to utilize my records, photographs, movies, or videotapes for publicity purposes and further authorize the same to publish all or portions of said records, photographs, movies, and videotapes for said purposes. I also authorize, for purposes of publicity, the release of my name and information regarding care and treatment.

I understand that the release of this information by the Ear Research Foundation for the purposes set forth above shall have NO responsibility or liability for the use of said information, its staff or others and I exonerate the Ear Research Foundation of any and all liability or claim that might arise in understanding any filming or in the use of the records, photographs, movies or videotapes of myself.

Applicant Name: _____

Applicant Signature: _____

If Minor, Parent/Guardian Signature: _____

CREDIT CARD FORM

Payment in the form of a credit card requires that all of the information below be completed.

1. Name on card: _____

2. Card mailing address: _____

_____

3. Card Type: ☐ Visa ☐ MasterCard ☐ American Express

4. Card Number: _____ **5.** Expiration Date: _____

6. CDIC Code (on back): _____ **7.** Amount to Charge ($100): _____

8. Signature: _____

NOTE: Your credit card will not be processed until your application has been approved.

Please provide a brief letter describing your hearing needs and how you feel this program will benefit you. This is a **required** component of your application. You may use the space below or your own stationery/paper. The letter can be neatly written by hand or typed.