Dear Applicant,

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

If you have attempted these avenues and been 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 applications will be notified by mail.

Selected applicants will be required to have a **hearing test** with one of our audiologists followed by a **physician's appointment** (in which testing will be reviewed and explained). *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*). 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.

Your application fee of $100 (payable by cash, check or credit card) will be processed ONLY after notification of selection. **If you are not selected**, your 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 patients insurance.** If patient does not have insurance, options including sliding scale cost and payment plans are available.

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

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

   Ear Research Foundation
   1901 Floyd Street
   Sarasota, FL 34232

2. **Electronically -** print, scan & email your 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 Markie Smith at (941) 556-4219 with questions regarding this matter or if you need further assistance.

Sincerely,

Markie Smith
Administrative Assistant

Jennifer Moss
Executive Director

Income Guidelines

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

2016 POVERTY GUIDELINES FOR THE 48 CONTIGUOUS STATES

Person in Family/Household	Poverty Guidelines
1	$11,880
2	$16,020
3	$20,160
4	$24,300
5	$28,440
6	$32,580
7	$36,730
8	$40,890

For families/households with more than eight people, add $4,160 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. **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)s
   – 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: ___________________

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.

Mailing Address: Street ____

Apt # _________ City ______________________________ State _________ Zip __________________

Home Phone: _____________________________ Alternate Phone: _______________________________

If patient is a Minor, Parent/Guardian's Name(s) Information:

Name: _____________________________________ Relationship to Applicant: __________________

Phone: _____________________________________

ADDITIONAL INFORMATION

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

	YES	NO	
Checking Account	☐	☐	If yes, provide all pages of 12 months current bank statements.
Savings Account	☐	☐	If yes, provide all pages of 12 months current bank statements.
Credit Card	☐	☐	If yes, provide most recent statement.
CD(s)	☐	☐	If yes, provide most recent statement.
Stocks/Bonds	☐	☐	If yes, provide most recent statement.
Annuity	☐	☐	If yes, provide most recent statement.
IRA/401(k)	☐	☐	If yes, provide most recent statement.
Money Market Acct	☐	☐	If yes, provide most recent statement.
Burial Account	☐	☐	If yes, provide 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? ______________________________

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 are 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 video tapes may be taken of my care and treatment and authorize the use of said photographs, movies or video tapes 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 video tapes for publicity purposes and further authorize the same to publish all or portions of said records, photographs, movies, and video tapes for said purposes. I also authorize, for purposes of publicity, 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 of 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 video tapes 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 unless/until your application has been approved.

EAR RESEARCH FOUNDATION
SILVERSTEIN INSTITUTE
Help Us Hear

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 stationary/paper. The letter can be neatly written by hand or typed.