HEARAID FOUNDATION

# APPLICATION FOR ASSISTANCE

(Service Provider Referral)

**GENERAL INFORMATION:**

Candidate's Name: _____ DOB: _____

Service Provider Name: _____

Facility: _____

Address: _____

Phone Number: _____-_____-_____ Email: _____

**Hearing Health Care Provider**

State Licensure/Registration Number: _____ Issued: _____

Board Certified Hearing Instrument Specialist (BC-HIS) Number: _____ Issued: _____

**I understand and agree to the following:**

1. I will not charge a hearing aid fitting fee to approved recipients.
2. I will provide one follow-up service at no additional fee to HearAid recipient.
3. I will submit audiological test results and other information deemed necessary to HearAid Foundation in order to provide optimal care to HearAid recipient.
4. I will follow state/federal guidelines necessary for obtaining medical clearance/waiver (if applicable) prior to fitting HearAid recipient with hearing instruments.
5. I will not advertise/market HearAid recipients for personal advertising purposes.
6. I will provide a brief written statement following the fitting to verify client receipt of the instrument(s).

**CLIENT INCOME ELIGIBILITY:**

| Number in Family | Annual Income | Number in Family | Annual Income | Number in Family | Annual Income |
|---|---|---|---|---|---|
| 2 | $29,140 | 4 | $44,100 | 6 | $59,060 |
| 3 | $36,620 | 5 | $51,580 | 7 | $66,540 |

*Each additional person add $7,480.* **Please submit a copy of your tax return or if not applicable a copy of your latest paycheck stub.** If the family income is at or below the listed amounts the candidate will be eligible. If the family does NOT meet the criteria or income is not available, please provide a written referral for that client.

**HEARING AID INFORMATION:**

Please complete the following information for the client's hearing aid(s):

Number of hearing aids requested: ❑ 1 ❑ 2 If (1) specify which ear: ❑ Right ❑ Left

Hearing aid style: ❑ ITE ❑ BTE Earmolds: ❑ Right ❑ Left

Provider's input: _____

_____

_____

If you have any questions please call Tanya Penn at HearAid Foundation:
**(949) 436-8218 or email info@hearaidfoundation.org.**

**Please submit referrals to:**
**HearAid Foundation, Inc., 446 Old Newport Blvd., Newport Beach, CA 92663**