HEARAID FOUNDATION

APPLICATION FOR ASSISTANCE

HearAid Foundation's Mission is to assist those in our community who seek, but have limited resources, to achieve their fullest hearing potential. If you or a loved one is interested in applying for hearing assistance, please complete the sections below and submit:

- ❑ First two pages of your tax return. If not applicable, submit a copy of at least three consecutive paycheck stubs.
- ❑ Your most recent hearing test (from within last year).
- ❑ This form filled out and signed.

Scan and email copy to: **hearaidfoundation@gmail.com**

GENERAL INFORMATION:

Candidate's Name: _____ Date of Birth:_____

Home Address:_____

County: _____

Phone Number:_____-_____-_____ Email:_____

How did you hear about HearAid Foundation: _____

Person Responsible:_____ Relationship: ❑ Self ❑ Mother ❑ Father ❑ Guardian

For demographic classification only I identify my ethnicity as:

❑ Asian ❑ Black/African ❑ Caucasian ❑ Hispanic/Latino ❑ Native American ❑ Pacific Islander ❑ Prefer Not To Answer

SERVICES:

I am not enrolled or eligible in any government/other funded programs (ie. Medicaid, CCS, etc): ❑ Yes ❑ No

If previous application denied, please specify reason:_____

_____

If candidate is a child is he/she insured under any health plan? ❑ Yes ❑ No

INCOME:

Total Household income for the past 12 months:_____

(Please include: Wages/Salary, Pension, Social Security, Child Support and any other income.)

EXPENSES:

Number of family members living in the household:_____

Total allowed deductions for the past 12 months:_____

(Please include: Total Medical/Dental not paid for by health insurance or third party, Annual Rent or Mortgage Payment, Annual Payments for primary vehicle, and Dependent Care (childcare and/or incapacitated adults receiving care).

RECIPIENT RESPONSIBILITY:

Once eligibility and funding have been reviewed and accepted, you will go through your audiologist/hearing aid dispenser to receive ear molds (if applicable) and hearing aids. HearAid Foundation Inc., will not accept financial responsibility for any additional test(s), treatment or office visits. By signing this form, you agree to release information to HearAid Foundation. Information specific to your (or your child's if applicable) hearing loss may be shared with other medical, audiological and intervention specialists or agencies in order to provide optimal care. Information that doesn't specifically identify the candidate may be published or used to pursue funding for HearAid Foundation.

I agree to pay $100 towards HearAid Foundation's "Pay It Forward" Program in order to help other recipients get the gift of hearing: ❑ Yes ❑ No ❑ Other amount_____

Candidate (or legal guardian) Signature :_____ Date:_____

HearAid Foundation, Inc. 446 Old Newport Blvd. Newport Beach, CA 92663
(949) 436-8218 or email at hearaidfoundation@gmail.com
Tax ID: 270220698