HEAR NOW Program

APPLICATION 2011

Valid through December 15, 2011

Starkey® Hearing Foundation

So the World May Hear®

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Dear Applicant,

Thank you for contacting the HEAR NOW Program of the Starkey Hearing Foundation for hearing aid assistance. Our hope is to provide hearing aids to those permanently residing in the U.S. who meet the criteria and are approved for assistance. The program is designed to assist those who have **no other resource** available to them. HEAR NOW is a program of last resort. Other options for assistance include: family support, insurance, state Medicaid program, vocational rehabilitation, school district, VA, church groups, state or local programs. Please call the HEAR NOW office to check your eligibility.

Assistance comes through manufacturer gifts, hearing health care providers in your area and donors across the U.S. The hearing health care provider is not reimbursed for his/her work with the HEAR NOW program. We deeply appreciate the time, effort and generosity they commit to HEAR NOW clients. We trust you will treasure the dedication and commitment of these generous individuals.

If the applicant has family support of **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**. Hear Now considers all these when determining eligibility. Only those who fall within the program guidelines for income, assets and hearing loss can be considered for assistance. The current non-refundable processing fee with the application is $125 per hearing aid requested. The hearing health care provider will assist the applicant in determining the number of aids needed to help the applicant hear better. Every applicant is asked to call Hear Now to discuss their eligibility for the program. Please call 1-800-328-8602 (ask for Hear Now) to discuss this with a program representative.

The application/processing fee is non-refundable.

INFORMATION TO CONSIDER BEFORE COMPLETING THE HEAR NOW APPLICATION

1. **Income Guidelines**: For 48 contiguous states and D.C. ONLY. To obtain guidelines for Alaska and Hawaii, please call 800.328.8602. **All income figures are NET. NET is the amount you actually receive in your check(s) regardless of source.**

Household	Income	Household	Income
1	$18,952	5	$45,132
2	$25,497	6	$51,677
3	$32,042	7	$58,222
4	$38,587	8	$64,767

NOTE: For family units with more than 8 members, add $3740 for each additional member.

2. **Application and Order Processing Fee:** $125 for one (1) aid **OR** $250 for two (2) aids.

3. **In determining eligibility, HEAR NOW considers the following:** all available funds, assets and hearing loss.

   a. **Household Size** (Household is defined as those living together or dependent on each other).

   b. **Net Monthly or Annual Income** from all in the household who have income. **Possible sources of income are:**

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

   c. **Assets** (include, but not restricted to)

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

HEAR NOW reserves the right to change eligibility criteria without prior written notice.

HOW TO COMPLETE THE PROCESS

1. **Read the application completely.**

2. **Call Hear Now to discuss eligibility for the program.**
    - The number to call is 1-800-328-8602 (ask for Hear Now).
    - Tell the representative you wish to discuss your eligibility for the program.

3. **Find a hearing health care provider in your area who works with Hear Now.**
    - Hear Now does not provide referrals to local offices.
    - Check your yellow page listings for Hearing Aids.

    Choose offices closer to you.

    - Make some calls to those offices to ask if anyone in that office works with the Hear Now program.
    - Schedule an appointment for a hearing test .
    - Have the practitioner complete page 9 of the application.
    - Obtain a copy of your hearing test results from the practitioner.

4. **Complete pages 4, 5, and 6 --the applicant's signature is required on page 6.**

5. **Complete page 10 — either the primary physician signs the top portion of the page or the applicant can sign the bottom of the page.**

6. **Gather income information for all those in the household.**

7. **Gather copies of bank statements —**
    - Statements are needed for each account belonging to each individual in the household. A copy of each page of each statement is required (that includes the copies of the checks).

8. **Gather the other necessary support documentation as outlined on page 5.**

9. **Include a Money Order or Cashier's Check for the processing fee ($125 per aid) payable to Starkey Hearing Foundation.**

    (Personal checks are not accepted.)

10. **DO NOT SEND ORIGINAL DOCUMENTS; THEY WILL NOT BE RETURNED TO YOU.**

11. **Mail all materials to:**

    Starkey Hearing Foundation
    6700 Washington Ave. S.
    Eden Prairie, MN 55344

12. **Once you have mailed the application to HEAR NOW, please wait at least 5 weeks before making a call for a status check of your application.**

*Additional information may be needed after initial review of the application.
**Hear Now reserves the right to change criteria at any time without prior written notice.

GENERAL INFORMATION

(Please Print Clearly)

Date: ______________________

Applicant's Name: First ______________________ Middle ____________________ Last ______________________________

Date of Birth: _______________ Age: __________ Social Security Number: _____________________ ☐ Male ☐ Female

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

Number in Household: ________________________ (Household is defined as all those living together or dependent on each other.)

Mailing Address:

Street____ Apt. #_______________

City ________________________________ County _______________________ State __________ Zip _________________

Home Phone:____ Work Phone:____

If applicant is a Minor, Parent/Guardian's Name(s): ____

Person, if other than applicant, completing this form. If Minor, list Parent/Guardian's Information

Name: ____ Relationship to Applicant: ___________________________

Phone: ____

INCOME

If applicant is a Minor, list Parent/Guardian's income information

List all sources of income (i.e., salary, social security, alimony, child support, pension, stocks, bonds, etc.) for all in the household.

Applicant:

A. ____ $ ___________________________ Month or Year (circle one)

B. ____ $ ___________________________ Month or Year (circle one)

Spouse/Other:

C. ____ $ ___________________________ Month or Year (circle one)

D. ____ $ ___________________________ Month or Year (circle one)

ADDITIONAL INFORMATION:

Applicant Name: ____

MARK 1 BOX FOR EACH ITEM. Unanswered questions will delay the process.

Do you currently have:	Yes	No	
Checking Account	☐	☐	If yes, provide all pages of 9 months of current bank statements
Savings Account	☐	☐	If yes, provide all pages of 9 months of 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/401k	☐	☐	If yes, provide most recent statement
Money Market Account	☐	☐	If yes, provide most recent statement
Burial Account	☐	☐	If yes, provide most recent statement
Do you live in subsidized housing?	☐	☐	If yes, provide documentation of approval notice and rent amount

If you own your home, how much are your property taxes? ______________________ Send current statement.

Are you a Medicaid recipient? ☐ Yes ☐ No

HOUSEHOLD INFORMATION:

Household is defined as all those who live together or are dependent on each other.

Number in Household: _______________

List names of individuals in household.

Name	Age of Person

Employment Status: ☐ Employed ☐ Other ☐ Retired

Name of Current Employer: ______________________________

Phone: ______________________ How long have you been employed there? ______________ (Years/Months)

RELEASE OF INFORMATION

I understand the information I submit to HEAR NOW concerning my annual income, family size, family resources, insurance, medical history and all financial information are subject to verification by HEAR NOW and/or their agents. This verification will be done by phone, letter, e-mail 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 the application/processing fee is non-refundable.

Applicant Name: ______________________ Spouse's Name: ______________________

Date of Birth: ______________________ Date of Birth: ______________________

Applicant Signature: ______________________ Spouse's Signature: ______________________

(If Minor, Parent/Guardian signature required)

If signed by Power of Attorney (POA), please send copy of POA. The laws of the state of Minnesota shall govern the resulting transaction and any claim or dispute arising out of such transaction.

Use this space to provide additional information, if necessary.

Dear Hearing Health Care Provider:

HEAR NOW, the US program of the Starkey Hearing Foundation, is committed to helping low income individuals who lack the resources to obtain needed hearing aids. Because the program works only with the help of generous, dedicated practitioners who care about the members of their community, your support of HEAR NOW clients is deeply appreciated. Practitioners are asked to waive their customary fees for fitting and follow-up for the first year of warranty coverage. You may assess your normal fee for the initial evaluation.

While interested practitioners are asked to donate their time and services to do the fitting and follow-up for the first year of warranty coverage, HEAR NOW provides the hearing aids to be fitted in your office. The Client Data Sheet (CDS) is an integral part of your client's application. An applicant's file is not complete without the CDS (page 9). The application is reviewed when the Client Data Sheet, audiogram, Client Application and support documents are received in the HEAR NOW office. It is helpful if all documents are sent at the same time.

Practitioners willing to waive their customary fees for fitting and follow-up for the first year and are licensed to dispense hearing aids in their state are eligible to work with the program. It is necessary to have practitioner licensure information on record at HEAR NOW. Please provide this information on the Client Data Sheet for each client. If the client is approved for hearing aid assistance you will be contacted by HEAR NOW with instructions regarding the ordering process. It is preferable that impressions are kept in the practitioner's office until authorization to order aids/earmolds is received from HEAR NOW.

HEAR NOW provides only BTE aids and earmolds to those who apply and qualify for assistance. All instruments provided through the program come with at least a one year warranty for repair. It is strongly recommended that extended warranty coverage for repair be purchased through the provider's office. Loss and Damage is not provided on Hear Now aids, but this coverage can be purchased through the provider's office.

The program has grown significantly over the years. It is expected that as the program continues to be discovered, the requests for assistance will continue to grow. Clients are asked to wait at least five (5) years before reapplying for new hearing instruments.

HEAR NOW reserves the right to change eligibility criteria at any time without written notice.

CLIENT DATA SHEET – MEDICAL/AUDIOLOGICAL INFORMATION

To be completed by the provider FITTING AIDS FOR CLIENT (Please Print Clearly)

Name of Client: ____________________ Date of Birth: ____________

PLEASE ATTACH: Air and Bone Conduction Audiogram, SRTs, MCLs and UCLs

Is the client currently aided? ☐ YES ☐ NO If yes, list make/model and how old? ____________

Number of aids requested: ________ **If fitting only one (1) ear,** which ear are you fitting? (check one) ☐ LEFT ☐ RIGHT

The only style of aid used in the program is BTE. Please mark you preference below.

Indicate your choice here:

Product line needed: ________ Starkey ________ Audibel

BTE requested: ________ 13 Battery ________ 312 Battery **RIC BTE options**

________ Trim Pot Digital Aid ________ Color of casing #______ RIC Circle one (5 7 9 11)

________ Destiny/Virtue 400/4, 800/8, 1200/12 ________ Color of casing #______ RIC IQ Circle one (7 9 11)

________ Destiny/Virtue 1200/12 power plus ________ Color of casing Color of casing ____________

________ S Series 5, 7, 9, 11 ________ Color of casing Receiver Length circle one (1 2 3 4 5)

________ S Series IQ (7 9 11) ________ Color of casing Receiver Gain circle one (40 50)

________ # of standard earmolds needed **OR** ________ size of slim tubing requested

I agree to become an associate of HEAR NOW for this client. I agree to provide services in accordance with state/federal guidelines. I understand that associates who receive hearing aids from HEAR NOW for their client agree to provide the services related to the fitting and follow-up without charge to the client for the first year of warranty coverage. HEAR NOW does not ask associates to waive any of their customary evaluation/hearing assessment fees. Charges related to the initial hearing evaluation are the client's responsibility.

PLEASE COMPLETE THIS SECTION FOR EACH CLIENT. THANK YOU.

Starkey Ship to Account #: ____________ **OR** **Audibel** Ship to Account #: ____________

Name of Professional: ____________________

Name of Business: ____________________

Address: ____________________

City: ____________________ State: ________ Zip: ____________

Phone: ____________________ Fax: ____________________

State Licensure/Registration #: ____________________

ASHA # ________ F-AAA # ________ IHS # ________ BC-HIS # ________

☐ I do not have my CCC-A. Supervised by: ____________________ State #: ____________

Signature: ____________________ Date: ____________

E-mail: ____________________

One of the following MUST be completed and submitted with the application.

MEDICAL CLEARANCE FOR HEARING AID USE

To be signed by client's Primary Physician

Date: ______________________

Patient Name (please print): ____

The patient listed above has been medically examined and may be considered a candidate for hearing aid use.

Physician Name (please print): ____

Physician Signature: ____

OR

WAIVER OF MEDICAL CLEARANCE FOR HEARING AID USE

To be completed and signed by the client

Date: ______________________

Client Name (please print): ____

I understand that it is in my best interest and recommended by HEAR NOW and the Food and Drug Administration to receive a medical examination before acquisition of hearing aids. I choose not to receive a medical examination before acquiring hearing aids.

Client Signature: ____

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