Help America Hear Scholarship Rules
2023/24 School Year

Who Can Apply

The scholarship is open nationally to high school seniors who have a hearing loss, which requires the use of hearing aids or Cochlear Implants in their daily life.

Purpose of Scholarship

The purpose of this scholarship is to help students with hearing loss reach their full potential by giving them a financial boost and the gift of sound. This will further allow the students to build confidence and self-esteem as they prepare for college or vocational school.

How it Works

The recipient of this scholarship will be selected by an independent group of judges to be determined by Help America Hear Inc., a 501c3 Not for Profit Corporation. The scholarship will award Ten students per school year, eight with hearing aids and two with Cochlear Implants/BAHA. Students wearing hearing aids that are three years old or less will only receive a financial award. Cochlear Implant users are also eligible, but will only receive the financial award.

What is the Award

The scholarship recipients will receive **two (2)** state-of-the-art *ReSound Hearing Aids* which best fit his/her hearing loss, plus a $4000 Scholarship towards the student's college or vocational school of choice. **The financial award is due to a matching grant from the Stavros Niarchos Foundation (SNF).

How it Works

The essay should highlight the student's creativity, academic achievements, community service and life experiences. It MUST also include, but is not limited to, responses to the following questions that pertain to the student's situation:

- What is hearing loss?
- How have your peers and teachers supported your academic achievements?
- Explain how your hearing loss has influenced your productivity in school?

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- What challenges do you face as a hearing-impaired student? How are you overcoming those challenges?
- Do you feel hearing aids have or will increase your ability to learn?
- List the ways hearing aids will improve your education, work and social goals. Explain what new activities you will engage in or pursue with new hearing aids.
- Upon receiving new hearing aids, how do you expect your life to change? What changes will you hope to achieve? Do you think your interpersonal relationships will be different?
- What are you looking to accomplish with your college degree and how will this award help you achieve your goals for the future?
- How will you advocate change for self-determination for students and individuals who are hearing impaired?

****Cochlear users can answer these questions as it relates to you.

Requirements

All essays **MUST** be between 500-1500 words, single-spaced in 12-point Arial font with 1" margins **PDF format ONLY**.

Additional documents required with the essay:

1. A completed scholarship application
2. Two (2) letters of reference. One from a teacher, a guidance counselor, coach etc., and one individual outside of school and family (ie. employer, community leader, college professor, etc.) Depending on the type of reference, each letter should include, but is not limited to:
    a. Why they recommend student for this scholarship
    b. A brief description of the student's social involvement in school and in the community
    c. Details of the student's academic performance
    d. Extracurricular activities
3. Photo of applicant
4. A copy of student's most recent Hearing Instrument Evaluation/audiogram
5. Copy of college or vocational school acceptance letter (if received)
6. A signed photo release (if student is a minor, then form must be signed by a parent or legal guardian). It is requested parents sign one as well. (form attached)
7. A signed HIPAA form (if student is a minor, then must be signed by a parent/legal guardian) (form attached)

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Judging

Judges will use the same scoring system & base their decisions on 4 overall criteria:

1. The writing quality of the essay, which includes grammar and punctuation.
2. The content – (i.e.) essay discusses ALL questions, as stated above, that pertain to student's situation
3. The student will benefit from the use of hearing aids ***Not Applicable for CI users
4. Student's activities and involvement in school, community and home

Important Information

Please email your essay, application and all other required documents, in an editable PDF format (preferred) and/or Word to:
info@helpamericahear.org

Important Information Regarding This Scholarship:

- **DEADLINE to submit essay/scholarship packet: SUNDAY, April 7, 2024**
- **Applications received after the deadline will not be considered.**
- **Winners will be selected and notified before or approximately by the month of June 2024.**
- **No employees or family members of Help America Hear Inc., ReSound or any other hearing healthcare industry entity may apply to this scholarship**
- **All essays and supporting materials submitted become the property of Help America Hear Inc. and are considered permissible to use for marketing and fundraising purposes.**

Help America Hear Inc. reserves the right to make any changes to its scholarship application & rules at any time without notice.

For questions or additional information about Help America Hear programs and scholarship, please visit www.helpamericahear.org or call (888)580-8886 or email at info@helpamericahear.org.

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Help America Hear Scholarship Application
2023/24 School Year

1) Student Information:

First Name: _____ Last Name: _____ DOB: _____

Address: _____ City: _____ State: ____ Zip: _____

Telephone Number: (____) _____
Email Address: _____

2) Parent Information:

Mother/Father/Legal Guardian (Preferred parental contact):

Parent #1
First Name: _____ Last Name: _____

Cell: (___) _____Email: _____

Parent #2
First Name: _____ Last Name: _____

Cell: (___) _____Email: _____

3) Student's Educational Information:

High School:

_____

City: _____ State: ____ Graduation Year: _____ GPA: ____

SAT Score: _____ ACT Score: _____ Other: _____

College or Vocational School you will be attending:

_____

City: _____ State: ____

Intended Major: _____ Intended Minor: _____

4) List And Describe Your Involvement In All Activities And Organizations:

_____
_____
_____

5) Hearing Aid Information

Year purchased:_____ Model:_____

Brand:_____ Purchased out of pocket or insurance?:_____

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6) Current Hearing Health Care Professional information

Name:_____

Practice Name:_____

Address:_____

Phone:_____

Email (if available):_____

7) CHECKLIST For The Help America Hear Scholarship:

☐ 1). The Completed Application Form
☐ 2). Written Essay
☐ 3). Two (2) Letters Of Reference
☐ 4). Copy Of Most Recent Hearing Instruments Evaluation
☐ 5). Hearing Specialist Checklist (Form Attached)
☐ 6). Copy Of College Acceptance Letter (If Received)
☐ 7). Photo Of Applicant
☐ 8). Signed Photo Release (Signed By Parent If Applicant Is Under 18, Form Attached)
☐ 9). Signed HIPAA Form (Signed By Parent If Applicant Is Under 18, Form Attached)

Please Type or PRINT clearly and email your essay, application and all other required documents, in an editable PDF (preferred) and/or WORD format, (no jpg), to: info@helpamericahear.org

Important Information Regarding This Scholarship:

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- **Winner will be selected and notified by month of June 2024,**
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Help America Hear Inc. reserves the right to make any changes to its scholarship application & rules at anytime without notice.

The applicant information collected is used exclusively to select a scholarship recipient. Applicants will be contacted only if there are clarifying questions regarding application information and to inform applicants of their status. Help America Hear reserves the right to make any changes necessary in the rules and process of the Scholarship Program.

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Help America Hear Program
Hearing Specialist Checklist

Your Hearing Specialist must initial each item below:

_____ Air conduction thresholds at 250-8kHz with contralateral masking when indicated

_____ Bone conduction thresholds at 250-4kHz with contralateral masking when indicated

_____ Speech Reception Thresholds and Speech Discrimination for each ear individually and binaurally, using masking when indicated

_____ Hearing Loss and Hearing Aid Use History

_____ Are any of the FDA contraindications (aka red flags) present?

Check one:

☐ Yes
☐ NO

_____ MCL

_____ UCL

SPECIAL NOTE:

This checklist must be initialed even if the test was performed prior to receiving the Help America Hear Application

Help America Hear Program
Applicant Medical Clearance

Must be signed by an Ear, Nose and Throat and/or Otolaryngologist Specialist *AFTER* they have reviewed the hearing evaluation.

******PLEASE NOTE******

The HELP AMERICA HEAR committee requires that ALL medical clearance is signed by an Ear, Nose and Throat and/or Otolaryngologist Specialist.

The purpose of this medical clearance is to determine that all medical issues pertaining to the use of hearing aid(s) are cleared.

Date: _____

Patient Name (please print):_____

PLEASE CHECK ONE:

☐ LEFT EAR ☐ RIGHT EAR ☐ BOTH EARS

Physician Name (please print):_____

Physician Signature: _____

By signing this form, I have medically cleared patient for hearing aids

Physician NPI Number: _____

"When sound fades to silence...
Help America Hear can help"

HELP AMERICA HEAR

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www.helpamericahear.org

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Smithtown, NY 11787

P 888-580-8886
F 631-360-1998

Help America Hear

Statement of Medical Clearance Waiver

A Medical Clearance Waiver is allowed IF there are NO red flags noted by a licensed hearing healthcare professional

Medical clearance will be required if any 'red flags' appear from a full Hearing test by a licensed audiologist, licensed hearing aid dispenser, ENT or deemed necessary by the Help America Hear Program.

I have been advised by _____(print name of audiologist), that the Food

and Drug Administration has determined that my best interest would be served if I had a medical evaluation by a licensed physician (preferably a physician who specializes in diseases of the ear) before receiving a new donated hearing aid.

I do not wish a medical evaluation before receiving a hearing aid.

I further understand that a copy of this statement will be kept on file by the named audiologist for a period of three years from this date, in accordance with the Food and Drug Administration regulations.

Name of Applicant_____

Applicant Signature_____

Address of Applicant_____

Date_____

Help America Hear Program
HIPAA Authorization

HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT (HIPAA) AUTHORIZATION:

For Use and Disclosure of Protected Health Information

By your signature below:

(1) I (Applicant) authorize Help America Hear Inc. and authorized representatives, including service providers to receive my health information;

(2) I authorize any licensed physician, medical practitioner, hospital, clinic, laboratory, Veteran's Administration, government facility, Hearing Professional, or other entity or person ("Providers") to disclose my health information;

(3) I acknowledge that this Authorization may be relied upon to determine my eligibility for receiving hearing aids from the Help America Hear Program or for any other business purpose not otherwise prohibited, including but not limited to any activities related to benefits or to support the business operations of this Company;

(4) I acknowledge that this Authorization expires two (2) years from the date it is signed;

(5) I acknowledge that I may revoke this Authorization at any time by, sending written notice to the Company's address, however, any revocation will not apply retroactively;

(6) I acknowledge that if I refuse to sign this Authorization, A Provider may not refuse to provide treatment or payment for health care services, however the Company may not be able to process this application or provide any benefit;

(7) I acknowledge that information disclosed pursuant to this Authorization may be redisclosed and no longer covered by certain federal rules governing privacy of health information; and

(8) I acknowledge that a copy of this Authorization, including a photographic or electronic copy of my signature, is valid as the original and I may receive a copy of this Authorization after it is signed.

I hereby authorize the designated parties below to request and received any protected health information regarding my treatment or payment.

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Applicant's Printed Name: _____

Applicant's (or Legal Guardian's) Signature: _____

Date: _____

Help America Hear Inc. reserves the discretionary right to modify its policies and procedures without notice.

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Help America Hear Program
Photo-Video Release

I, (print name) _____, hereby grant permission to *Help America Hear Inc.* (HAH) and the Hearing Healthcare Provider, (in addition to any production company hired by HAH) to create copy, reproduce, exhibit, publish and distribute any photos or videos/DVDs.

I understand that the above uses may include, but are not limited to videotapes, films, sound recordings, photographs, displays, brochures, websites, multi-media programs, or any other type of promotional medium existing currently or in the future. I, hereby waive, any present or future right to inspect or approve the finished photographs, printed electronic, or electronic matter.

Furthermore, I understand that by granting this permission I am irrevocably surrendering all rights and/or claims to monetary compensation for any future use of this material by the above persons and organizations. I herein give permission to the HAH and their Hearing Healthcare Provider(s) to contact me in the future.

I am 18 years old and I am competent to contract in my own name. I have read this release in its entirety before signing below and I fully understand the contents, meaning, and potential impact of this release. I am fully aware that I have the right to submit questions, in writing, prior to signing the release and I agree that my failure to do so will be interpreted as a free and knowledgeable acceptance of these terms.

_____ _____

Signature Parent/Guardian (if under 18)

_____ _____ _____

Address City State/Zip

_____ _____

Phone Date

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