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

HELP AMERICA HEAR

info@helpamericahear.org
www.helpamericahear.org

PO Box 1245
Smithtown, NY 11787

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

Dear Applicant,

Help America Hear Inc. is a 501c3 not for profit organization which raises funds for programs to enhance the quality of lives for people with vision and/or hearing challenges.

We welcome you to *Help America Hear*, a nationwide program, which helps individuals in low-income situations receive the gift of hearing aids.

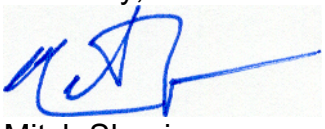
This is a program of **LAST RESORT** and we kindly ask you to consider all possible options, before applying to our program. We trust that you will deeply appreciate the kindness of all those funding this program, and as a courtesy to them, we ask all applicants to ensure their financial eligibility. If you have **family** support, financial investments and substantial funds in your checking/savings then, ***this program is probably not for you*.**

Please be advised that the *Help America Hear* committee considers all these income prerequisites when determining the applicant's eligibility. If you do not fall within these specific guidelines or are for some other reason deemed ineligible, we reserve the right to deny assistance. After reading through all documentation, if you are unsure of your parameters please contact us to discuss.

Help America Hear is sponsored by the generosity of the Hearing Health Care Industry.

We hope you understand our mission, which is to bring the beautiful gift of sound to Americans in need.

Sincerely,



Mitch Shapiro
Help America Hear Program Committee

Help America Hear Program
Income & Qualification Guideline

The Help America Hear Program Provides Three Tiers Based on Various Financial Criteria

Look over the guidelines and select one tier. If you are unsure of the appropriate tier, please call: 888-580-8886 or send us an email: info@helpamericahear.org for further clarification.

Help America Hear only provides behind the ear and receiver in canal devices and custom molds

TIER 1: ☐

- Gross annual household income $25,000 or less
- No financial assets*
- No benefits towards the cost of hearing aids

(If you have financial assets* you may qualify for Tier 2 or Tier 3)

  - $125 application fee per hearing aid; $250 for two hearing aids

TIER 2: ☐

- Gross annual household income $25,001 - $30,000
- Allowable financial assets not to exceed a total of $5,000*
- With a hearing aid benefit of $500 or less for two hearing aids

  - $300 application fee per hearing aid; $600 for two hearing aids
  - Must send $125 per hearing aid *to start process;* upon approval balance is due**

TIER 3: ☐

- Gross annual household income $30,001 - $35,000
- Allowable financial assets not to exceed a total of $10,000*
- With a hearing aid benefit of $500 or less for two hearing aids

  - $500 application fee per hearing aid; $1000 for two hearing aids
  - Must send $125 per hearing aid *to start process;* upon approval balance is due**

***Financial assets may include** *funds in checking and/or savings accounts, money market accounts, mutual funds, 401(k) plans, IRAs, stocks, bonds, CDs, or T-bills, annuities and trust funds.*

****TIER 2 & 3:** *Only send in $125 per hearing aid to start the application process; balance due upon approval*

Help America Hear Program
Application Checklist

***********ALL ITEMS LISTED BELOW MUST BE INCLUDED***********

(Any missing documents will delay the process of your application)

IMPORTANT NOTE: You must read all documentation before starting the process to ensure your understanding of how our program works.

✓ = Completed	Requirement
	Application
	Complete Hearing Instruments Evaluation (also known as an Audiogram) – not older than 3 months •The form entitled "Hearing Specialist Checklist" must be returned with this application •This checklist must be initialed even if the test was performed prior to receiving the Help America Hear Application
	Applicant Medical Clearance •You must bring the results of your Hearing Evaluation •Have your Medical Clearance signed AFTER Hearing Evaluation and **ONLY BY an Ear, Nose and Throat and/or Otolaryngologist Specialist**
	HIPAA Authorization
	Affidavit •Must be notarized
	Photo-Video Release
	Proof of Income •Most recent Tax Return (if filed) ***AND/OR*** •Social Security or Social Security Disability Year-End Statement
	Three Months of Bank Statements – detailed statements with all activity
	Three Months of Credit Card Statements are required for all credit cards (if none mark N/A)
	Payment must be included with application * Please refer to **Income & Qualification Guideline page** for Tier Descriptions and check (✓) appropriate Tier ❑ **Tier 1** ❑ **Tier 2** ❑ **Tier 3** We accept credit cards, checks or money orders Checks must be written to "**Help America Hear**" *****If your application has been denied for any reason a portion of your fee will be refunded.

Return this checklist with your application!

ENSURE ALL PERTINENT ITEMS LISTED ABOVE ARE PUT IN ONE ENVELOPE WHEN MAILING - DO NOT USE STAPLES

Mail all the items above to: **Help America Hear** PO Box 1245 Smithtown, NY 11787 **OR** Email to: info@helpamericahear.org **OR** Fax to: 631-360-1998 (with a note that payment is being mailed separately)	The Help America Hear Committee has the right to approve or deny any documents. Once your application has been approved, we will contact you with the name and location of a HAH.

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

Help America Hear Inc. does not discriminate on the basis of race, color, national origin, religion, sex, age, disability, sexual orientation, or military status in its selection process.

Help America Hear Program Application

I. GENERAL INFORMATION: Date: _____

Applicant's Name: First _____ Middle _____ Last _____

Street Address: _____

City, State, Zip: _____

Telephone Number _____ Email _____

Social Security Number: _____Date of Birth: _____

Sex (**Circle one**): **Male** **Female** Marital Status (**Circle one**): **Married** **Single** **Divorced** **Widowed** **Separated**

If Minor (under the age of 18) is applying provide Parent/Guardian's Name (print): _____

Parent/Guardian Signature: _____

Employment Status (**Circle one**): **Employed** **Retired** **Other** (please describe): _____

Name of Current Employer: _____

Phone Number: _____ Length of Employment: _____

Are you a Veteran? (**Circle one**): **YES** **NO** if yes, have you checked if you are eligible for VA benefits? _____

***If person, other than applicant is completing this form or if the parent/guardian's mailing address is different than stated above; please provide his/her contact information below:**

Name: _____ Relationship to Applicant: _____

Mailing Address: _____

Phone Number: _____ Email: _____

****DO WE HAVE APPLICANTS PERMISSION TO DISCUSS ANY INORMATION WITH CONTACT LISTED ABOVE** Yes/No**

II. INSURANCE INFORMATION:

☐ Medicare ☐ Medicaid ☐ Other: (please specify) _____

Medical Insurance: ☐ NO ☐ YES – Please describe: _____

Name of Secondary/Supplemental Insurance _____

Do you have a hearing aid benefit? ☐ NO ☐ YES – If yes which type of benefit do you have. A copay, One or two aids covered, how often are they covered and how much does your benefit pay_____

Specialist Name (who completed your audiological testing): _____

Company Name: _____

Address: _____

City, State, Zip: _____

Phone Number: _____ Email: _____

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

Help America Hear Inc. does not discriminate on the basis of race, color, national origin, religion, sex, age, disability, sexual orientation, or military status in its selection process.

Help America Hear Program Application

III. HEARING AID INFORMATION:

Do you presently wear hearing aids (circle one): **YES NO**

If yes, make/model/year purchased: _____

IV. HOUSEHOLD INFORMATION:

We realize each household has a different set of circumstances which affect their livelihood and financial situation. What the review board needs is a better understanding of your monthly expenditures. Please fill out the amount for each of the following as it pertains to you.

Number in Household: _____ (*Household is defined by all those financially dependent on each other)*

Do you live with family members other than spouse? (**Circle one**): **YES NO**

Please list the names of the individuals who are considered YOUR financial dependents, (if any):

Name:	Age of Person:
_____	_____
_____	_____
_____	_____

Do you own a home? (**Circle one**): **YES NO**

If yes, (type of Mortgage/Balance: _____ Property Tax (yearly): _____

Line of Credit/Balance: _____ Home Equity Loan/Balance _____

If you rent your living space, how much is the rent?: _____ALSO if you rent, please describe (i.e. apartment in a private home, apartment in a building,
etc)_____

Utilities (monthly cost): Electric _____ Gas_____ Phone (Land/Cell) _____ Water _____
Internet/Cable _____

Do you own a 2nd Home, Trailer or Rental Property? (**Circle one**): **YES NO if yes give details**
_____

Do you own/lease a vehicle? (**Circle one**): **YES NO** if yes, Monthly payment: _____ Gas _____
Maintenance _____

Other forms of transportation (ex: public bus) _____

INSURANCES/MEDICAL: Home _____ Life _____ Health/Medical _____

Direct Out-of-pocket medical expenses: Doctor _____ Prescriptions _____

Hospitalization_____ Dental _____

V. MISCELLANEOUS:

Home Improvements/Maintenance_____

Groceries_____ Dining Out _____

Credit Cards: _____Balances:
_____Limits_____

Other expenses (please explain): _____

What is your disposable income; money left after all your expenditures? _____

Please provide any documentation or written explanation of medical hardships and/or financial challenges
_____

Income for Applicant:

A. _____ Income: _____Monthly or Annually (**circle**)

Income for Spouse/Other:

B. _____ Income: _____ Monthly or Annually (**circle**)

C. _____ Income: _____ Monthly or Annually (**circle**)

VI. REFFERAL INFORMATION:

Who referred you to the Help America Hear Program?
_____

What is their profession or relation to you? _____

How can we contact them if necessary? _____

VII. LOCATIONS:

Help us in locating a provider in your area. Please provide a minimum of 3 zip codes and/or names of towns within a 50- mile radius that you can travel to:

_____ _____ _____

The process can take up to 6 months. Your assistance in providing us with names and phone numbers of Hearing Aid Centers, Audiologists, ENTs, and local hospitals in your immediate area will shorten the process.

PLEASE READ FAQ's REGARDING LENGTH OF TME AND LOCATION OF PROVIDER

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: _____

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 receive 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.

Help America Hear Inc. does not discriminate on the basis of race, color, national origin, religion, sex, age, disability, sexual orientation, or military status in its selection process.

Help America Hear Program
Affidavit

----------(print name)----------, affirms under penalty of perjury that the following documents provided to *Help America Hear Inc.* are true and correct: HAH Application, Audiogram, and Income Disclosure Documentation.

By signing this affidavit, I certify the annual gross household income conditions imposed by *Help America Hear Inc.* were met and I acknowledge no other means of income (i.e. *family support or funds in money market accounts, mutual funds, 401(k) plans, IRAs, hidden checking or savings accounts, stocks, bonds, CDs, or T-bills, etc.)* except what was disclosed to *Help America Hear*.

Gross Annual Household Income Conditions are specified as follows:

Tier 1 applicants cannot exceed $25,000.
Tier 2 applicants cannot exceed $30,000.
Tier 3 applicants cannot exceed $35,000.

Moreover, all statements declared in these documents have remained the same as when first submitted, and are true, to my own knowledge except in those matters outside of personal jurisdiction.

_____ _____

Applicant's Signature Date

_____ _____

Notary Name (please Print) Notary Signature

_____

Date

NOTARY STAMP and SIGNATURE MUST BE PLACED DIRECTLY ON THIS FORM. IT CAN NOT BE SUBMITTED ON A SEPARATE SHEET OF PAPER.

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 at least 18 years of age 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

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

Help America Hear Inc. does not discriminate on the basis of race, color, national origin, religion, sex, age, disability, sexual orientation, or military status in its selection process.

HELP AMERICA HEAR PROGRAM – FAQs

1. **How does someone apply for a hearing aid?**
   - In order to apply, you will need to include all the paperwork outlined on page two of the application.
2. **Who is eligible for a hearing aid?**
   - Men, Woman, and Children who make less than $35,000, have hearing aid-treatable moderate to profound hearing loss and no other financial means of purchasing hearing aids.
3. **Why is there an Application Fee?**

   Help America Hear is a 501c3 not-for-profit organization and therefore 100% of the application fees associated with the Help America Hear program are used to cover overhead expenses. HAH is a small grass roots organization and requires a small office staff to maintain daily operations and ensure that people like you continue to receive the help they need. We understand the value and importance of your hard- earned money and we will be more than happy to discuss any questions or concerns you may have.
4. **Is the application fee refundable?**
   - If the applicant is denied, a percentage of the application fee will be returned, based on the time spent processing the application.
5. **How long does it take to get a hearing aid?**
   - Depending on receipt of all pertinent documentation will determine how long the process takes.
   - Once all paperwork is received review/approval time is 2-3 weeks.
   - The entire application process from start to finish can take 2-6 months.
6. **Upon being approved how do we receive the hearing aids?**
   - Each approved applicant is assigned to a Hearing Health Care Professional that agrees to work with the Help America Hear Program.
7. **How long does it take to find a provider?**

   This can take from 2-6 months depending on several factors:
   - Whether or not your original provider agrees to work with the program.
   - The time it takes for a provider to agree to fit our approved applicant and sends back their agreement.
   - Finding a Hearing Health Care Professional who dispenses or is willing to dispense ReSound Hearing Aids.
8. **What can I do to help expedite the process?**
   - All applicants are asked to provide a minimum of 3 zip codes in that they can travel to. It is also advised that applicants assist by finding a professional who is willing to work with Help America Hear.
9. **How does a Hearing Health Care Professional participate in the program?**
   - The professional is made aware of the program by the applicant or is approached by a member of the Help America Hear Team.

HELP AMERICA HEAR PROGRAM- FAQs
cont'd

10. What if there is nobody in my area?

- We strive to find a provider as close to the applicant's home as possible. Applicants must be willing to travel up to a 50-mile radius of their hometown.

11. What types of hearing tests are required?

- An Audiogram Exam which includes binaural speech scores, air, bone masking, mcl and ucl levels. (Have your examiner initial each item on the checklist included in the application to ensure all tests were completed). Applicant is responsible for the cost of the hearing test. Although, many insurance companies do not cover hearing aids, several do cover testing. If you have insurance coverage currently, call the number on the back of your insurance card.

12. What kind of hearing aids do you provide?

- We provide new ReSound BTE (behind the ear) and RIC (receiver in canal) digital hearing aids.

13. If I have a hearing aid benefit can I still apply?

- Yes, if you have a hearing aid benefit your application will be considered a Tier 2 application and the fees will be higher than Tier I.

14. What if I can't afford the application fee?

- Our suggestion is for you to contact your local religious entity, civic organization (such as Rotary, Lions, Kiwanis) and your local Elected Officials. Let one of these avenues be aware that you are applying to Help America Hear for Hearing Aid assistance. It has been proven that when you ask for a "hand-up" not a "hand-out" you will have a better opportunity.

15. What is the Photo Release form?

- By signing this form, it provides a means of approval by you to show the success of the program.

16. What am I entitled to once I receive my hearing aids?

- From your first visit you will receive a total of 3-5 visits or up to one year of service depending on the individual Health Care Professional.

17. What additional costs can I expect beyond the application fee?

- You may be charged for batteries, additional accessories, extended warranty (strongly recommended), or additional testing as deemed necessary by the hearing health care provider.