Dear Applicant,

Thank you for applying with the Fisher Foundation for Hearing Health Care for hearing aid assistance. We are a 501c3 not for profit organization which raises funds to enhance the quality of lives for people with hearing challenges. Our goal is to provide hearing aids to those who meet the criteria for assistance. The program is designed to assist those who have no other resource available to them. Fisher Foundation is a program of last resort. Other options for assistance include: family support, insurance, state Medicaid program, vocational rehabilitation, school district, church groups, and state or local programs.

Fisher Foundation for Hearing Health Care considers all assets when assessing eligibility of applications. Including, money market accounts, mutual funds, 401(k) plans, IRAs, CDs (certificates of deposit), checking/savings accounts, stocks, bonds, T-bills or property. Only those who fall within the program guidelines for income, assets and hearing loss can be considered for assistance.

As part of our process, you must first agree to apply for a medical credit card through Wells Fargo or Care Credit. We can assist you with this process. If denied, we will proceed with assessing eligibility through the Fisher Foundation for Hearing Health Care. If approved, you will receive the hearing aids at no cost. However, a **nonrefundable professional fee of $250.00 will be charged**.

We hope you understand our mission, which is to enhance the quality of life through better hearing to those in need.

Sincerely,

Ronna Fisher

Ronna Fisher, Au.D. FAAA
Founder and President
Fisher Foundation for Hearing Health Care

Fisher Foundation for Hearing Health Care reserves the discretionary right to modify any of its policies and procedures without notice. Fisher Foundation for Hearing Health Care does not discriminate on the basis of race, color, national origin, religion, sex, age, disability, sexual orientation, or military status in its selection process.

142 E Ontario Suite 1100
Chicago, IL 60611
P: 312-465-4155

Eligibility Requirements

• Applicant must have a hearing loss that requires amplification (hearing aids): children with a mild or greater hearing loss, and adults with a moderate or greater hearing loss.

• Applicant has no other resources available. Other resources include, but are not limited to: insurance, state Medicaid program, VA or vocational rehab, state or locally provided/funded programs, other charity sources, denied financing to pay for hearing aids.

• Applicant must complete an application form and provide a current audiogram.

• Children 18 years and younger must have medical clearance dated within the last 6 months signed by a physician (MD, ENT). While medical clearance is encouraged for adults, a signed medical waiver is acceptable.

• Applicant must have an income level which does not allow the family to receive public support – see specific income eligibility requirements. Total household income must be at or below the chart provided to qualify and demonstrate personal inability to financially provide for hearing health.

• Applicant must possess a family commitment to intervention, rehabilitation, and necessary follow-up services, which is especially important for a child applicant as they grow.

• Applicant must be a resident or citizen of the U.S. or Puerto Rico. Note: Repeat adult applicants will not be considered if they received hearing aids through the Foundation within 5 years of the new application submission. Child applicants will be considered every 3 years, if family still fits the criteria. Repeat applicants must submit a new application.

You will receive notification by mail within 4 weeks if your application has been approved or denied services. For more details on the process, refer to www.fisherfoundationforhearing.org or if you have other questions about your eligibility, please call 1-312-465-4155

Loss or Damage

• For children, 18 years and younger, if a hearing aid is lost or damaged within 2 years of receipt from the Foundation, a notarized letter detailing the situation must be presented to the Foundation to replace the hearing aid. The Fisher Foundation for Hearing Health Care will not replace a hearing aid due to loss more than once in lifetime. For adults, there will be no replacement for loss or damage.

• Repair of hearing aids of any kind is not covered by Fisher Foundation for Hearing Health Care.

• Provided proper care and maintenance of the earmold and hearing aid(s) have been taken as instructed, the Foundation will provide new ear mold(s) for children only based on their changing need. Up to one time every 3 years, or 2 times total, whichever comes first.

General Information

Date: _______________

Applicant Name: First: ______________________ Middle _______________ Last ________________________

Sex: M ____ F ____ Birthdate: ____________________

Address: _________________________________ Apt #: ____ City: _________________State: ____ Zip: _______

Home Phone: _____________________Work Phone: _____________________ Cell: _______________________

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

Social Security # ____________________________ E mail address ___________________________________

If Minor (under the age of 18) is applying, provide Parent/Guardian name (print):_____________________

Parent/Guardian Signature____________________________________

Person, if other than applicant, completing this form:
Name: ____ Phone: _______________________________

Relationship to Applicant: _____________________________________

Employment Status (Circle One): **Employed** **Retired** **Other** (please describe):________________

____

Employer: _______________________ Address: _________________________City: ___________State: ___ Zip: _____

Full Time __________ Part Time __________ Occupation _________________________

Former Occupation _____________________________________ Not Employed ___________

How long have you been employed there? _______________ (Years / Months)

Were you ever provided hearing aids by Fisher Foundation for Hearing Health Care? **Yes** **No**

If yes, date/year received____________________

Have you ever applied for assistance to purchase hearing aids through public or community programs? **Yes** **No**

If yes, organization/date/year received____

Income Guidelines

Applicant must have an income level which does not allow the family to receive public support for hearing health care. Total household income must be at or below the chart provided to qualify and demonstrate personal inability to financially provide for hearing health.

Family Size	Total Household Income
1	$23,540
2	$31,860
3	$40,180
4	$48,500
5	$56,820
6	$65,140
7	$73,460
8	$81,780

INCOME AND INSURANCE

Mark one box for each item. Form must be complete to process application

Do you have or currently receive the following. Please list amounts

	Yes	No	Amount
Checking Account	☐	☐	$____________
Savings Account	☐	☐	$____________
Pension/Retirement	☐	☐	$____________
Money Market Account	☐	☐	

	Yes	No	Amount
Social Security Income	☐	☐	$______/mo
Supplemental Social Security Income (SSI)	☐	☐	$______/mo
Child Support	☐	☐	$______/mo
Do you live in subsidized housing?	☐	☐	

Household Monthly Net Income from Employment (after taxes) $____________________

Total Cash Value of Assets (do not include cars, principle place of residence, or life insurance policy) $________________

<u>Note: Please attach a copy of the most recent tax return (1040/1040A) for everyone in the household. If you do not file taxes and receive government benefits, please submit the award statement(s) of these benefits.</u>

Insurance Information: Please check all that apply

☐ Medicare ☐Medicaid ☐Other (please specify)______________________________

Medical Insurance: ☐No ☐Yes- Name/Policy start date________________________________

Name of Secondary/Supplemental Insurance ____

Do you have a hearing aid benefit? ☐No ☐Yes- Which type of benefit and how much ______________________

MONTHLY EXPENSES

Rent/Housing	$ ____________
Dependent Care	$ ____________
Tuition/Loans	$ ____________
Electricity	$ ____________
Gas	$ ____________
Water	$ ____________
Telephone	$ ____________
Other Utilities	$ ____________
Monthly Medical Expenses	$ ____________
Other Expenses	$ ____________
Total Expenses:	$ ____________

OTHER ELIGIBILITY

Are you eligible for:

Federal Housing Assistance/Section 8	Yes ______	No ______
SNAP (food stamps)	Yes ______	No ______
Low Income Energy Assistance Program	Yes ______	No ______
Illinois Cares Rx	Yes ______	No ______
Medicaid	Yes ______	No ______

HOUSEHOLD INFORMATION

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

Number in Household: ___________

List names of individuals in household.

Name	Age of Person

RELEASE OF INFORMATION

I understand the information I submit to Fisher Foundation for Hearing Health Care concerning my annual income, family size, family resources, insurance, medical history and all financial information are subject to verification by Fisher Foundation 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 that if I receive hearing aids through the Fisher Foundation for Hearing Health Care, I am responsible for contributing a nonrefundable professional fee of $250.

Applicant Name: _______________________________ Spouse's Name: __________________________________

Date: ________________________________ Date: ____________________________________

Applicant Signature: ____________________________ Spouse's Signature: _______________________________

Parent/Guardian Name: _________________________ Date: ______________________________

Parent/Guardian 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 Illinois shall govern the resulting transaction and any claim or dispute arising out of such transaction.

HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT (HIPAA) AUTHORIZATION:

For Use and Disclosure of Protected Health Information

By your signature below:

(1) I (Applicant) authorize Fisher Foundation for Hearing Health Care 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 Fisher Foundation for Hearing Health Care 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;

(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 re-disclosed and no longer covered by certain federal rules governing privacy of health information

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

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: ____________________________________

142 E Ontario Suite 1100
Chicago, IL 60611
P: 312-465-4155

Date: _________________________________

APPLICANT TESTIMONIAL CONSENT and RELEASE FORM .

Foundation Recipient (Individual/Family) Testimonial Consent and Release Form

Purpose of Consent: By signing this form, you are hereby granting the Fisher Foundation for Hearing Health Care, its parent company, and others working for or on its behalf including, but not limited to, advertising agencies, promotion agencies, and fulfillment agencies (the "Licensed Parties") to use and publicize your name, and/or the name(s) of the person reflected below, your/their testimonial(s), and any information contained therein, including certain individually identifiable health information, for advertising, promotion and other commercial and business purposes, which may be distributed to the public in various formats.

Right to Revoke: You have the right to revoke this Release at any time by providing written notice of your revocation and submitting it to: Fisher Foundation for Hearing Health Care, 142 E Ontario Suite 1100, Chicago, IL 60611 Attn: Foundation Coordinator

Note: Revocation of this Release will not affect any action or use of your testimonial and the information contained therein prior to our receipt of revocation.

CONSENT AND RELEASE

I/we hereby permit and authorize the Licensed Parties to display, publicly perform, exhibit, transmit, broadcast, reproduce, record, photograph, digitize, modify, alter, edit, adapt, create derivative works, or otherwise use and permit others to use my/our/their name and testimonial and any information contained therein, including certain individually identifiable health information, as well as other and all materials created by or on behalf of the Licensed Parties that incorporate any of the foregoing, on a perpetual basis in any medium or format whatsoever now existing and hereafter created for the purpose of advertising, public relations, publicity, packaging and promotion of the Licensed Parties and their products and services without further consent from or royalty, payment or other compensation to me/us/them.

I/we/they understand that I/we/they shall have no right of approval, no claim to additional compensation, and no claim related to any use of the above. I/we/they also agree that I/we/they will have no rights in or to any and all copyrights, photographs or other creative works in which any of the above are used.

By signing this Release I/we/they agree and acknowledge that I/we/they have read and understood the above Release and agree to all terms described and confirm that I of legal age, have the legal authority to represent all the individual person(s) named below and freely sign this Release.

____

Recipient Printed Name Date

____

Recipient or Parent/Guardian Signature

Person(s) Covered by this Testimonial Consent and release Form:

Full Name Relationship to the Signer (Self/Child/Dependent, etc.)

___________________________________ ____

___________________________________ ____

In order for this application to be reviewed and considered, all of the following must be included with the application:

☐ Copy of signed audiogram-dated within the last three months

**If you do not have an updated hearing test, one can be administered at any Hearing Health Center location. You must call and make an appointment*

☐ Completed application

☐ Copy of most recent tax return (104 and/or 104A or government benefits if you do not have a 104/104A)

☐ Most recent Social Security or Social Security Disability- Year End Statement (If applicable)

☐ Sign and date the Release of Information and HIPPA forms

Fisher
Foundation
FOR HEARING HEALTH CARE