Application for Assistance Programs

(PLEASE READ ENTIRLY BEFORE FILLING OUT THE APPLICATION!!!)

What is the Hearing and Speech Foundation?

The mission of the Hearing and Speech Foundation (HSF) is to empower individuals with communication deficits to live their lives to the fullest. We accomplish our mission through the following programs: hearing aid assistance (domestic and international); training for professionals; research and development in speech perception; auditory therapy for children and adults; and hearing aid recycling. All services from the Foundation are granted on a first-come, first-served basis. In the event that funding is not available at the time your application is processed and you are pre-approved for services, your name will be placed on a waitlist. As soon as funding is available we will contact you via postal mail to notify you of your final approval.

What services do you provide?

Hearing Aid Assistance:
The Foundation provides hearing aids and hearing services, including audiological exams and earmold impressions. The majority of the aids provided by the Foundation are behind-the-ear hearing aids. In-the-ear hearing aids are used if they are available and if they provide the proper amplification for your hearing loss. The type of hearing aid you are fitted with is determined only by the audiologist. Hearing Aids we have available may be new, manufacturer refurbished or thoroughly evaluated and tested used aids donated through our recycling program. Once approved and fitted the hearing aid(s) is yours and you are free to have follow-ups with any service provider of your choice. Initially all of our clients receive treatment from Blount Hearing and Speech Services, located in Maryville, TN. All hearing aids received are your property and should be cared for as directed. We ask that in the event you are no longer using the aids that you consider donating them back to the Foundation as they may help someone in the future. If approved, you are not eligible to re-apply for services for 3 years after your last approval date.

Therapy Services:
Certified professionals with HSF use the Verbotonal Method of auditory training to improve the listening skills of both hearing impaired and normal hearing individuals. Clients of any age can be served individually or in small groups, depending on their needs. A typical session is one hour in length, during which the client may use personal hearing aid/s, cochlear implants or specialized auditory equipment provided by HSF. Parent counseling and contact with school personnel is offered when appropriate.

Who is eligible and what is the cost?

Eligibility for our programs is determined by household income and extenuating personal and financial circumstances. We use the U.S. Department of Health and Human Services Federal Income Guidelines to determine client eligibility and fees for services. We accept clients whose gross annual household income does not exceed 100% above the poverty line. **Fee payment is required at the time of service, unfortunately we do not have a payment plan.**

What information do I need to apply?

A copy of the following documentation **must** be included with your completed application. Failure to do so will result in a delay in processing your application:

- A completed application for assistance (attached)
- **Verification of residency** You may submit a utility, cable, or phone bill or a copy of your driver's license if the address is correct. (Must be a street address, no post office boxes)
- **Proof of household income** – **Latest IRS 1040 tax return form** and you may be asked to submit a Social Security statement (and/or SSI), an alimony statement, VA benefits statement, retirement pension statement, retirement investment statement, disability income statement, or a check stub from your employer.
- **Copies of medical health insurance card(s)**—front and back

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2019 U.S. Department of Health & Human Services

Federal Income Guidelines:

Household Size	Poverty	25% above	50% above	75% above	100% above
1	$12,490	$15,613	$18,735	$21,858	$24,980
2	$16,910	$21,138	$25,365	$29,593	$33,820
3	$21,330	$26,663	$31,995	$37,328	$42,660
4	$25,750	$32,188	$38,625	$45,063	$51,500
5	$30,170	$37,713	$45,255	$52,798	$60,340
6	$34,590	$43,238	$51,885	$60,533	$69,180
7	$39,010	$48,763	$58,515	$68,268	$78,020
8	$43,430	$54,288	$65,145	$76,003	$86,860
Over 8	Add $4,420 for each additional person				

Current Sliding Scale Fees for Services

Cost PER	Poverty	25% Above	50% Above	75% Above	100% Above
Hearing Aid*	$150	$200	$250	$300	$350
Test & Fitting	$50	$60	$70	$80	$90
Two Follow Up Visits	$100	$120	$140	$160	$180
Ear mold*	$20	$30	$40	$50	$60
1ST AID	**$320**	**$410**	**$500**	**$590**	**$680**
2ND AID*	**$170**	**$230**	**$290**	**$350**	**$410**
TOTAL	**$490**	**$640**	**$790**	**$940**	**$1,090**

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Instructions for filling out the application:

- Make sure all blanks and blocks are filled in. If a question does not apply to you, then write NA for "not applicable." Please do not leave anything blank.
- Make sure **all** verification documents are included with your application.
- Make sure you have signed all the signature locations.
- Completed applications are reviewed as received. Services may be delayed if we have to contact you about missing documents or incomplete application.
- Once your application is reviewed, our office will send a letter of your client status with the Foundation. Assistance is first come, first served.

You can submit your completed application by email, mail, fax, or bring it directly to our office. If you have any further questions or need help completing an application, please contact our office and ask to speak with our Outreach Program Coordinator, we will be happy to assist you.

John A. Hinkle
Executive Director & Foundation Board Member
1619 E. Broadway Ave Maryville, TN 37804
Phone: (865) 977-0981 / Fax: (865) 977-5444 / Email: jahinkle@handsf.org

If you have questions specific to our therapy services please contact our Therapy Services Coordinator, Leslee Rook at (865)-977-0981 or Leslee@handsf.org.

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Please fill out <u>ALL</u> the following information for services from the Hearing and Speech Foundation.

Which services are you applying for: ☐ Hearing Aid Assistance ☐ Auditory Therapy

Have you applied for Foundation services before? ☐ Yes ☐ No If yes, when? _____

CLIENT INFORMATION

Applicant's Name: _____ Date of Application: _____

Address: _____ Applicant's Date of Birth: _____

City: _____ State: _____ Zip: _____ County: _____

Home phone: _____ Work phone: _____

Cell phone: _____ Email: _____

Person completing application if not applicant: _____

Relationship to applicant: _____ Contact Phone Number: _____

Do you have health insurance? ☐ Yes ☐ No

If yes, please list your primary insurance provider: _____

Marital Status: ☐ Married ☐ Widowed ☐ Divorced ☐ Single ☐ NA – Child

Gender: ☐ Male ☐ Female **Are you a U.S. Veteran?** ☐ Yes ☐ No

Are you currently receiving public assistance? ☐ Yes ☐ No

If yes, please list services you currently receive (such as TennCare, CoverKids, food stamps, etc): _____
_____

Ethnicity: ☐ Caucasian (Non-Hispanic) ☐ African American ☐ Latino American ☐ Native American
☐ Hispanic American ☐ Asian American ☐ Other (please specify):_____

How did you find out about the Foundation?_____

FINANCIAL INFORMATION

Total number of individuals and dependents (including yourself) living in your household/home: _____

Please list name, age & annual income of each on the next page and attach documentation:

Do you have investment or retirement (pension, IRA, etc) accounts? ☐ Yes ☐ No
(if Yes, you must provide a statement showing value of the account)

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1. _____, _____, $_____
Name (Applicant) **Age** **Annual Income**

2. _____, _____, _____ $_____
Name **Age** **Relationship** **Annual Income**

3. _____, _____, _____ $_____
Name **Age** **Relationship** **Annual Income**

4. _____, _____, _____ $_____
Name **Age** **Relationship** **Annual Income**

5. _____, _____, _____ $_____
Name **Age** **Relationship** **Annual Income**

6. _____, _____, _____ $_____
Name **Age** **Relationship** **Annual Income**

7. _____, _____, _____ $_____
Name **Age** **Relationship** **Annual Income**

8. _____, _____, _____ $_____
Name **Age** **Relationship** **Annual Income**

I certify the financial information provided on this application is true to the best of my knowledge AND I HAVE ENCLOSED DOCUMENTATION WITH THIS APPLICATION TO VERIFY MY HOUSEHOLD INCOME.

_____ _____
Applicant Signature **Date**

PLEASE BE SURE TO FULLY COMPLETE, REVIEW, SIGN, AND DATE THE FORM

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OBSERVATION AGREEMENT AND APPEARANCE RELEASE FORM:

There will be opportunities for the Foundation to observe and photograph applicant services. Allowing the Foundation to observe these services helps us to monitor programs and supplement reporting activity for funding---pictures always help tell the story. Please indicate whether you would allow the Foundation to observe and/or photograph your services.

I will allow the Foundation to observe me while receiving services. ☐ Yes ☐ No

I will allow the Foundation to photograph me receiving services for use in media presentations, publications and fundraising. ☐ Yes ☐ No

HSF may contact me for research purposes, including, but not limited to, participation in studies and ongoing research programs. ☐ Yes ☐ No

For good and valuable consideration, the receipt of which is hereby acknowledged, I hereby grant the Hearing and Speech Foundation the right to release and broadcast my name, face, character, voice and/or likeness without any compensation of any kind. This release applies to, but is not limited to, usage in any print materials, brochures, print ads, commercials, promotional announcements, public service messages, or news programs.

I further consent to the reproduction and/or authorization by the Hearing and Speech Foundation to reproduce and use said photographs and recordings of my voice, for use in all domestic and foreign markets. Further, I understand that others, with or without the consent of the Hearing and Speech Foundation may use and/or reproduce such photographs and recordings.

I hereby release the Hearing and Speech Foundation, and any of its associated or affiliated companies, their directors, officers, agents, employees and customers, and appointed advertising agencies, their directors, officers, agents and employees from all claims of every kind on account of such use.

Print Name: _____

Signature: _____

Date: _____

If Model is under 18

I, _____, am the parent/legal guardian of the individual named above. I have read this release and approve of its terms.