4280 Hale Parkway • Denver CO • 80220
303-751-2519 • www.hearproject.org

APPLICATION FOR ASSISTANCE

TO BE COMPLETED BY PARENTS OR GUARDIAN

Patient Information

Date: _____

Name of Child: _____

Date of Birth: _____ Place of Birth: _____

Gender: ___Male ___Female

Parent/Guardian Name:

Mother: _____ Father: _____ Guardian: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Mom Phone: _____ Dad Phone: _____ Guardian Phone: _____

Email: _____

Family Information

Family size: ____ # of Wage Earners ____ # of Adults ____ # of Children

Annual Household Income (including wages/salary, pension, social security, child support): _$_____

Annual Taxable Income (proof of income details are in the “Documentation” section below): _$_____

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H.E.A.R. PROJECT

Insurance Information

Is applicant covered by private health insurance? ___Yes ___No

Is applicant covered by secondary health insurance? ___Yes ___No

Is applicant covered by Medicaid of CHP+? ___Yes ___No

If answers to any of the above questions is yes, please explain why funding is being pursued and provide supporting documentations as requested (attach additional pages as necessary).

___Insurance Denial of coverage ___High Deductible or co-insurance ___Other

_____

_____

_____

Audiologic Information

Managing audiologist: _____ Phone: _____

Educational Audiologist: _____ Phone:_____

Age at diagnosis of hearing loss: _____

Cause of hearing loss (if known): _____

Did your child pass the newborn hearing screening? ___Yes ___No

Has your child ever worn hearing aids? ___Yes ___No

When were child's current hearing aids fit? (if applicable) _____

Are you currently receiving services from an early intervention program for your child (speech therapy, CHIP)?

___Yes ___No

Is your child receiving services under a 504 plan or IEP plan or receiving private speech therapy?

___Yes ___No

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Documentation

PLEASE SEND THE FOLLOWING REQUIRED DOCUMENTS

Please send copies – originals will not be returned

___Most recent federal income tax return pages 1 and 2

___A recent picture of your child

___Documentation of insurance if applicable (e.g. denial letter, documentation of high deductible/co-insurance, etc.)

RELEASE OF INFORMATION I understand that the information that I have submitted is, to the best of my knowledge, accurate and complete and subject to verification. I also understand that if I knowingly omit information or submit false information, my application will be eliminated and my consideration for assistance will be terminated. It may be necessary for a representative of the H.E.A.R. Project to communicate with your child's dispensing or educational audiologist. Your signature grants permission to discuss your child's audiometric needs. Please circle below if permission is granted to use your child's photograph in the H.E.A.R Project photo album, which is used for fund−raising purposes. It may be removed at any time at your request.

Upon approval of this application from HEAR Project, we agree to the following:

a) To be fiscally responsible for the maintenance, daily care, batteries, repairs, ear molds and replacement of my child's hearing aids in the future.
b) To return the hearing aids purchased by HEAR Project to HEAR Project if my child no longer needs the hearing aids. The hearing aids will be used as loaners for other children.
c) To notify HEAR Project Coordinator immediately if a change in any information occurs and/or you receive any additional funding through private insurance or any other third party funding assistance program.

Permission to use your child's photograph ___YES ___NO

Signature of Parent/Guardian: _____ Date: _____

Signature of Parent/Guardian: _____ Date: _____

****** Form can be emailed to applications@hearproject.org, and can also be faxed to: 303-751-2519******

The HEAR Project reserves the right to change the eligibility criteria at any time without written notification. The program will provide funding for hearing aid amplification as long as the funds for the program are available.