11500 N. Portland Ave.
Oklahoma City, OK 73120
Phone: (405) 548-4300
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FINANCIAL ASSISTANCE APPLICATION

Date of Application________________________________ Referral Source____

Patient Name____ Date of Birth_________________________ Age__________

Is your child on an IEP?___________ If so, what school district does your child attend?__________________________________

Name of Responsible Party____ Relationship to Patient_______________________

Address____
Street City State Zip code County

Phone____ Cell Phone____

Email Address:____

Funding is being requested for

_____Hearing Aids _____Earmolds _____Audiological Services _____Auditory-Verbal Therapy _____Education

Please attach a copy of your income tax return for the past year indicating your adjusted gross income. The completed application must be processed and approved prior to the assignment of financial assistance for services rendered.

1. Annual adjusted gross income: Last Tax Return $____________________ Prior Year $_______________________

2. Current income earned from employment:

Parent/Guardian (1) Occupation__________________________ $_____________________Hour/Year

Parent/Guardian (2) Occupation__________________________ $_____________________Hour/Year

If unemployed, monthly unemployment compensation amount $____________________________
How long unemployed____________________________________ Unemployment remaining $______________________

3. Other assets: Businesses, Cash, savings, stocks, bonds, CD's, second home, recreational vehicles, etc. (exclude retirement funds, i.e. IRA):

____ $______________________________
____ $______________________________
____ $______________________________

Other income:
Please specify source _______________________________________ $______________________________

4. Total number in household_________________________

Parent's current marital status ____single ____married ____separated ____divorced ____widowed

Parent's highest level of education

____High school
____GED
____Trade school
____Community college
____Associate's degree
____Bachelor's degree
____Master's degree
____Doctorate

List all persons living in the home with applicant (Applicant's name first)

1. ____ Relationship_____________________________
2. ____ Relationship_____________________________
3. ____ Relationship_____________________________
4. ____ Relationship_____________________________
5. ____ Relationship_____________________________
6. ____ Relationship_____________________________

Monthly Expenses

Home: ____Own Mortgage payment $________ Property taxes/monthly $_______ Monthly payment $__________
____ Rent Rent paid to ____ Monthly payment $__________

Utilities/month $__________________

Medical Bills

Monthly medical costs (include explanation and name of doctor/hospital/clinic)

____ $____________________________
____ $____________________________
____ $____________________________
____ $____________________________

Total monthly expenses $____________________________

Insurance Coverage
(Please submit a copy of the front and back of each insurance card)

PRIMARY Insurance
Insurance company name____

Subscriber's name____

Subscribers ID#____

Group or policy #____

Subscriber's date of birth____

Relationship to patient____

SECONDARY Insurance
Insurance company name____

Subscriber's name____

Subscribers ID#____

Group or policy #____

Subscriber's date of birth____

Relationship to patient____

Should your family have unusual or specific hardship circumstances, please describe specifics in a separate letter to be included with this application.

In order to process this proposed application, the following items must be submitted with this signed application:
1. Most recent income tax return 2. Current picture of your child 3. $25 Non-refundable processing Fee
4. Current IEP (if applicable)

Certification: I (we) certify that all the information on this form is true and complete to the best of my (our) knowledge. If asked by any authorized official of Hearts for Hearing, I (we) agree to give documentation for information given on this form. I (we) realize that failure to comply with a request for further information may prevent the applicant from receiving any aid. I (we) hereby authorize the Financial Assistance committee or any other investigative agency employed by Hearts for Hearing to investigate the references herein listed or statements of other data obtained from me (us) or from any other person pertaining to my (our) credit and financial responsibility. I (we) understand that if I (we) am/are approved for a discount I (we) may be required to provide explanation of benefits from our insurance carrier for our appointments.

☐ I am (we are) completing this application due to the immediate overwhelming medical expenses secondary to my (our) child's hearing loss.

Applicant's signature____ Date__________________________