



Dr. Ann Stadelmaier Hearing Aid Fund
Financial Assistance Application

www.hearingevaluationservices.com

Applicant's Name _____ Date _____

Street _____ City _____ State ___ Zip _____ Phone _____

Social Security Number ___/___/___ Number **Living** in Household ___ Adults ___ Children's Ages _____

Employer _____ Job Title _____

Name of Person Needing Assistance _____ Age ___ Relationship to Applicant _____

Health Insurance Provider _____ Medicaid: YES / NO Medicare: YES / NO

Emergency Contact Name _____ Relationship _____ Phone _____

Name of Audiologist/Physician _____ City _____ Phone _____

Do you currently have a Hearing Aid(s)? **Y N** Which Ear(s)? **L R** How Old? _____ Type? _____

I hereby authorize the above named Audiologist/Physician to release any information necessary to process this application.

Signature of applicant, Parent or Guardian _____ Date _____

Household Income and Asset Declaration: Please include a copy of pages 1 and 2 of your most recent IRS Tax Return and supporting documentation for all items marked YES (✓) with this application.

TYPE OF INCOME	CHECK ONE (✓)	IF YES, GIVE AMOUNT		Who Receives?
Social Security / Social Security Disability including direct deposit (Gross monthly deposit before deductions)	<input type="checkbox"/> YES <input type="checkbox"/> NO	MONTHLY AMOUNT \$ _____	Amount deducted for: Medicare Part B \$ _____ Medicare Part D \$ _____	
Supplemental Security Income (SSI)	<input type="checkbox"/> YES <input type="checkbox"/> NO	MONTHLY AMOUNT \$ _____		
Pension/Retirement (All types)	<input type="checkbox"/> YES <input type="checkbox"/> NO	MONTHLY AMOUNT \$ _____	Source of Pension	
Veteran's Benefits	<input type="checkbox"/> YES <input type="checkbox"/> NO	MONTHLY AMOUNT \$ _____		
Disability private or NYS	<input type="checkbox"/> YES <input type="checkbox"/> NO	WEEKLY AMOUNT \$ _____	Source	
Contribution (from someone outside household)	<input type="checkbox"/> YES <input type="checkbox"/> NO	WEEKLY AMOUNT \$ _____	Name of Contributor	
Child Support Received	<input type="checkbox"/> YES <input type="checkbox"/> NO	COURT ORDERED WEEKLY AMOUNT \$ _____	Source	

TYPE OF INCOME	CHECK ONE (✓)	IF YES, GIVE AMOUNT		Who Receives?
Alimony including payments for mortgage, utility bills, etc.	<input type="checkbox"/> YES <input type="checkbox"/> NO	MONTHLY AMOUNT \$ _____	Source	
Rental Income (apartment, garage, land, etc.)	<input type="checkbox"/> YES <input type="checkbox"/> NO	MONTHLY AMOUNT \$ _____	Type of Rental	
Room/Board (received) etc.	<input type="checkbox"/> YES <input type="checkbox"/> NO	MONTHLY AMOUNT \$ _____	Name of Roomer/ Boarder?	
Worker's Compensation	<input type="checkbox"/> YES <input type="checkbox"/> NO	WEEKLY AMOUNT \$ _____		
Unemployment Benefits	<input type="checkbox"/> YES <input type="checkbox"/> NO	WEEKLY AMOUNT \$ _____		
Total value of all savings, checking, CD's, money market accounts, etc.		Savings \$ _____ Checking \$ _____ CD's \$ _____ Money Market \$ _____ Other \$ _____	Source(s)	
Interest from savings, checking, CD's, money market accounts, etc.	<input type="checkbox"/> YES <input type="checkbox"/> NO	Yearly AMOUNT \$ _____	Source(s)	
Total value of all stocks, bonds, etc.		Stocks \$ _____ Bonds \$ _____	Source(s)	
Dividends from stocks, bonds, securities, etc.	<input type="checkbox"/> YES <input type="checkbox"/> NO	Yearly AMOUNT \$ _____	Source(s)	
Does anyone in the household work? If yes, submit wage stubs for the past four (4) weeks	<input type="checkbox"/> YES <input type="checkbox"/> NO	WEEKLY AMOUNT before deductions \$ _____ _____ WEEKLY AMOUNT before deductions \$ _____	Employer _____ Employer	
Is there any other income from any other source?	<input type="checkbox"/> YES <input type="checkbox"/> NO	Yearly AMOUNT \$ _____	Source(s)	

I fully understand that the Dr. Ann Stadelmaier Hearing Aid Fund services are limited to persons unable to pay, or who do not receive assistance from other sources. In consideration for such services, I hereby release and discharge all persons rendering such service from any claims that might arise from services or assistance provided. I understand that all information provided will be treated confidentially in accordance with HIPAA regulations. I give consent to release the minimum necessary information to additional sources that may assist in the funding of this hearing aid.

Signature of Applicant, Parent or Guardian

Date Signed