So The World May **Hear**

starkey HEARING FOUNDATION

APPLICATION 2020

Valid through December 31, 2020

HEAR NOW Program

www.starkeyhearingfoundation.org

Dear Applicant,

Thank you for contacting Starkey Hearing Foundation's Hear Now program for hearing aid assistance. Our hope is to provide hearing aids to those permanently residing in the US who meet the criteria and are approved for assistance. The Foundation program assists those **who lack the resources to acquire hearing aids**. Other options for assistance include: family support, insurance, state Medicaid program, vocational rehabilitation, school district, VA, church groups, state or local programs. **Please call the Hear Now office to check your eligibility.**

Assistance comes through manufacturer gifts, hearing healthcare providers in your area and donors across the US The hearing healthcare provider is not reimbursed for his/her work with the Hear Now program. We deeply appreciate the time, effort and generosity they commit to Hear Now clients. We trust you will appreciate the dedication and commitment of these generous individuals.

If you have family support or **funds** available in money market accounts, mutual funds, 401(k) plans, IRAs, CDs (certificates of deposit), checking/savings accounts, stocks, bonds, T-bills or property, **this may not be the program for you**. Hear Now considers all possible funding sources when determining eligibility. Only those who fall within the program guidelines for income, assets and hearing loss will be considered for assistance. The current application processing fee is $125 per hearing aid requested. **If an application is denied, the processing fee will be returned.**

The hearing healthcare provider will assist you in determining the number of hearing aids needed to help you hear better. Since there is a five-year timeline for reapplying for assistance, the number of hearing aids should be chosen carefully. Once the application is approved, the number of hearing aids cannot be changed. **Every applicant is asked to call Hear Now to discuss their eligibility for the program.** Please call 1-800-328-8602 (ask for Hear Now) to discuss this with a program representative.

The hearing aids provided by the program are high quality and new. All hearing aids come with warranty for repair only. Loss and damage coverage is not provided on the hearing aids through the program. This coverage can be purchased through the office with which the applicant is working. Ask the provider about warranty coverage options.

Your privacy is important to us:

- Application materials are viewed by Hear Now staff only.
- Applicant's financial papers are shredded.
- Names and addresses of applicants are never sold or shared with others.
- Hear Now reserves the right to change eligibility criteria without prior written notice.

When application is complete, mail to:

Hear Now Program
6801 Washington Avenue South, Suite 200
Minneapolis, MN 55439

HOW TO COMPLETE THE PROCESS

Read the application, then call Hear Now (1-800-328-8602 — ask for Hear Now) to discuss eligibility

ALL ITEMS SHOULD BE CHECKED OFF BEFORE MAILING

- ☐ Find a hearing healthcare provider in your area who works with Hear Now. (Call your local hearing aid office and ask if anyone in their practice works with Hear Now).
- ☐ Schedule a hearing test (send a copy with application — must be less than 9 months old).
- ☐ Have hearing provider (who works with Hear Now) complete pages 8 and 10 of the application.
- ☐ Send pages 8 and 10 with the application along with copy of audiogram.
- ☐ Complete pages 3 through 6 — with your required signature on pages 3, 5, and 6 — where doctor signs the top as clearance, or applicant signs the bottom portion as waiver of clearance (either is acceptable).
- ☐ Provide proof of income for all in the household and from all sources.
- ☐ Provide copies of the most recent six bank statements (all accounts, for all household members, and all pages of each statement).
- ☐ Provide documentation for any item to which you responded "YES" on page 5.
- ☐ Purchase a money order or cashier's check for the processing fee — $125 for one hearing aid or $250 for two hearing aids - Payable to Starkey Hearing Foundation. **Personal checks are not accepted. If an application is denied, the processing fee will be returned.**

INFORMATION TO CONSIDER BEFORE COMPLETING THE HEAR NOW APPLICATION

1. **2020 Income Guidelines:** All income figures are NET, the amount you actually receive regardless of source.

PERSONS IN HOUSEHOLD	48 CONTIGUOUS STATES AND D.C. YEAR	48 CONTIGUOUS STATES AND D.C. MONTH	ALASKA YEAR	ALASKA MONTH	HAWAII YEAR	HAWAII MONTH
1	$24,280	$2,024	$30,360	$2,530	$27,920	$2,327
2	$32,920	$2,744	$41,160	$3,430	$37,860	$3,155
3	$41,560	$3,464	$51,960	$4,330	$47,800	$3,984
4	$50,200	$4,184	$62,760	$5,230	$57,740	$4,812

2. **Application and Order Processing Fee:** $125 for one (1) hearing aid **OR** $250 for two (2) hearing aids payable to Starkey Hearing Foundation.

3. **In determining eligibility, we consider the following: funds available from all sources, assets and hearing loss.**

   a. **Household Size** (household is defined as those living together or dependent on each other)

   b. **Net Monthly or Annual Income** from all in the household who have income. **If working, provide your most recent paystub with year-to-date earnings.** Possible sources of income are:

   - Social Security and SSI
   - VA Pension
   - Child Support
   - Public Assistance
   - Alimony
   - Welfare
   - AFDC
   - Disability
   - Work Pension
   - Wages
   - Old Age Pension
   - Black Lung Payments
   - Interest from Stocks, IRAs, 401(k)s

   c. **Assets**

   - Checking
   - Money Market Accounts
   - IRA/401(k)
   - Reverse Mortgage
   - Savings
   - CDs
   - Home Equity Loan
   - Stocks/Bonds
   - Burial Accounts
   - Property
   - Annuities

RESPONSIBILITIES AND EXPECTATIONS

Your participation in the Hear Now application process establishes a partnership with us. Before you submit your application paperwork, we need you to be aware of the responsibilities connected with this partnership. After you have read the following information, sign and date the bottom of the page.

1. **The hearing provider recommends the aids that are best for your loss**
   - Once the aids are ordered, changes are not permitted
   - There is no trial period during which the hearing aids can be exchanged
   - The provider contributes five (5) appointments at no charge during the first year of warranty

2. **The aids come with limited warranty coverage**
   - Three (3) years of repair warranty is standard on most aids
   - The aids have no coverage for Loss & Damage (L & D) coverage
   - L & D coverage can be purchased by the applicant through the provider's office
   - Without the purchase of L & D coverage, aids cannot be replaced by the program
   - Individuals cannot reapply to Hear Now for five years

3. **Care of the aids, the responsibility of the applicant, include:**
   - Cleaning of the aids on a regular basis
   - Purchase of batteries on an ongoing basis
   - Contacting the provider when the aids seem not to be working properly

4. **Some expenses apply once an application is approved**
   - Purchase of batteries
   - Replacement of receivers and/or earmolds
   - Repair when warranty expires
   - Purchase of extended repair warranty and/or L & D warranty coverage, if you elect to do so.
   - Office visits after the first five

Hear Now reserves the right to change eligibility criteria without prior written notice.

Applicant Signature: _____ Date: _____

GENERAL INFORMATION

(Please print clearly)

Date: _____ Email: _____

Applicant's Name: First: _____ Middle: _____ Last: _____

Date of Birth: _____ Age: _____ Social Security Number: _____ ☐ Male ☐ Female

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

Number in Household: _____ (Household is defined as all those living together or dependent on each other.)

Mailing Address:

Street: _____ Apt. #:_____

City: _____ County: _____ State: _____ ZIP: _____

Home Phone: _____ Work Phone: _____

Cell Phone: _____

If applicant is a minor, parent/guardian's name(s): _____

Person, if other than applicant, completing this form. If minor, list parent/guardian's information.

Name: _____ Relationship to Applicant: _____

Phone: _____ Email: _____

INCOME

If applicant is a minor, list parent/guardian's income information.

List all sources of income (i.e. salary, social security, alimony, child support, pension, stocks, bonds, etc.) for all in the household.

Applicant:

A. Source of Income _____ $_____ Month or Year (Circle One)

B. Source of Income _____ $_____ Month or Year (Circle One)

Spouse/Other:

C. Source of Income _____ $_____ Month or Year (Circle One)

D. Source of Income _____ $_____ Month or Year (Circle One)

ADDITIONAL INFORMATION

Applicant's Name: _____

MARK 1 BOX FOR EACH ITEM. (Unanswered questions will delay the process.)

Do you currently have:	**Yes**	**No**	
Checking Account	☐	☐	If yes, provide all pages of six (6) months of current bank statements
Savings Account	☐	☐	If yes, provide all pages of six (6) months of current bank statements
CD(s)	☐	☐	If yes, provide most recent statement
Stocks/Bonds	☐	☐	If yes, provide most recent statement
Annuity	☐	☐	If yes, provide most recent statement
IRA/401k	☐	☐	If yes, provide most recent statement
Money Market Account	☐	☐	If yes, provide most recent statement
Burial Account	☐	☐	If yes, provide most recent statement
Are you a Medicaid recipient?	☐	☐	
You served in the US Military?	☐	☐	

Does your health insurance (or Medicare Supplement) offer a benefit for hearing aids? ☐ Yes ☐ No

If yes, how much is that benefit? _____

HOUSEHOLD INFORMATION

Number in Household: _____ **Household is defined as all those who live together or are dependent on each other.**

List names of individuals in household, and relationship to applicant. **Age of Person**

_____ _____

_____ _____

_____ _____

Employment Status: ☐ Employed ☐ Other ☐ Retired

RELEASE OF INFORMATION

I swear that the information in this application is true and correct to the best of my knowledge. I understand the information I submit to Hear Now concerning my annual income, family size, family resources, insurance, medical history and all financial information is subject to verification by Hear Now and/or their agents. This verification will be done by phone, letter, email 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, and I will be required to reimburse the Hear Now program for any benefits I may have already received. (If minor, parent/guardian signature required. If applicant is not married, a witness signature is required.)**

Applicant's Name: _____ Spouse's Name: _____

Date of Birth: _____ Date of Birth: _____

Applicant's Signature: _____ Spouse's Signature: _____

If signed by power of attorney (POA), please send copy of POA. The laws of the state of Minnesota shall govern the resulting transaction and any claim or dispute arising out of such transaction.

ONE OF THE FOLLOWING MUST BE COMPLETED AND SUBMITTED WITH THE APPLICATION

OPTION 1: MEDICAL CLEARANCE FOR HEARING AID USE

TO BE SIGNED BY APPLICANT'S MEDICAL DOCTOR

Date: _____

Applicant's Name (please print): _____

The applicant listed above has been medically examined and may be considered a candidate for hearing aid use.

Physician's Name (please print): _____

Physician's Signature: _____

EITHER OPTION CAN BE USED

OPTION 2: WAIVER OF MEDICAL CLEARANCE FOR HEARING AID USE

TO BE COMPLETED AND SIGNED BY THE APPLICANT

Date: _____

Applicant's Name (please print): _____

I understand that it is in my best interest and recommended by Hear Now and the Food and Drug Administration to receive a medical examination before acquisition of hearing aids. I choose not to receive a medical examination before acquiring hearing aids.

Applicant's Signature: _____

Pages 8 & 10 to be completed by Hearing Professional only

PROVIDER COMPLETES

PROVIDER COMPLETES PAGES 8 AND 10

IF YOU ARE A NEW PROVIDER, CALL HEAR NOW FOR INFORMATION ON HOW THE PROCESS WORKS.

Name of Applicant: _____ Date of Birth: _____

As a Hear Now provider, I understand and agree to the following:

1. I will not charge a hearing aid fitting fee to Hear Now approved client(s). I may charge the customary hearing evaluation/assessment fees.
2. I will provide up to five (5) appointments during the first year of warranty coverage. After the first year of warranty expires, any charges related to repairs/services will be the client's responsibility.
3. I will submit results of audiologic testing and other information requested on the hearing healthcare provider form as needed to determine audiologic eligibility, prognosis for improvement, and make/model of instrument(s) recommended for applicants.
4. I will follow state/federal guidelines relative to obtaining medical clearance/waiver prior to fitting Hear Now clients with hearing instrument(s).
5. If I am unable to work with the stipulations of the program, I will encourage the patient to find a different provider.
6. I understand that changes to the aid selection cannot be made once the aids are ordered.
7. Any theft or fraud, or other violations of the law, committed by me while participating in this program will be reported by the Foundation to my local authorities and the Foundation will seek reimbursement for related losses.

I attest to the fact that I am licensed/registered in my state to dispense hearing aids.
I agree to work with Hear Now under the above stated stipulations.

Provider Signature: _____ Date: _____

PLEASE COMPLETE THIS SECTION FOR EACH CLIENT

Each requested item serves a purpose. The Foundation uses this information to notify the patient and the provider when Hear Now approves the application and ships hearing aids and earmolds.

Ship to Account # (Account # address should match address below): _____

Name of Professional: _____ Gender (Circle One): F M (provider)

Name of Practice: _____

Address: _____

City: _____ State: _____ ZIP: _____

Phone: _____ Fax: _____

Email Address: _____

State Licensure/Registration #: _____

ASHA #: _____ F-AAA #: _____ HIS #: _____ BC-HIS #: _____

Audiogram Required

Request a copy from
your hearing professional
and place here

PROVIDER COMPLETES

TO BE COMPLETED BY PROVIDER FITTING THE HEARING AIDS

Applicant Name: _____ Date of Birth: _____

Ship to Account #: _____

Custom hearing aids are not available through Hear Now.
All available hearing aids are Muse i2400 wireless technology.

BTE OPTIONS

Number of aids: 1 2

If fitting only one ear: Left Right

Which power:	Mini	Standard	Power +
Gain	60	70	80
Battery	312	13	13

Earmolds 0 1 2

Earmolds should be ordered on Hear Now order forms ONLY

Color Choice: (Circle one)

Black Slate Sterling Espresso Bronze Champagne

RIC OPTIONS

Number of aids: 1 2

If fitting only one ear: Left Right

Volume Control	Micro RIC	Standard RIC
	Programmable Push Button	Rocker Switch

Battery 312 312

Receiver Options:

Standard (uses buds or RIC Molds) 50 60

Embedded in AP Molds 50 60 70

Receiver Length: 1 2 3 4 5

Earmolds 0 1 2

Earmolds should be ordered on Hear Now order forms ONLY

Color Choice: (Circle one)

Black Slate Sterling Espresso Bronze Champagne

☐ **Software** ☐ **Cables** ☐ **Boots**

☐ **Thin Tubing: Indicate Length** _____ ☐ **Left** ☐ **Right**

☐ **Ear Buds:** **Small** _____ **Medium** _____ **Large** _____

Open _____ **Occluded** _____

☐ **Swatch Chip**

☐ **Fitting Tool**

☐ **User Manual in Spanish**

If CROS or BICROS aids needed, indicate which side is transmitter

☐ **Left** ☐ **Right**

Earmolds should be ordered on Hear Now order forms ONLY

If you need CROS, BiCROS, Body or Bone Conduction aids, call **1-800-328-8602**

Starkey Hearing Foundation
Hear Now Program
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