HEAR NOW Program

APPLICATION

Starkey Hearing Foundation

So the World May Hear®
Dear Applicant,

Thank you for contacting the HEAR NOW Program of the Starkey Hearing Foundation for hearing aid assistance. Our hope is to provide hearing aids to those permanently residing in the U.S. who meet the criteria and are approved for assistance. The program is designed to assist those who have **no other resource** available to them. HEAR NOW is a program of last resort. 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 health care providers in your area and donors across the U.S. The hearing health care 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 treasure the dedication and commitment of these generous individuals.

If an applicant has family support or **funds** available in money market accounts, mutual funds, 401(k) plans, IRAs, certificates of deposit (CDs), checking/saving accounts, stocks, bonds or T-bills, **this may not be the program for you.** HEAR NOW considers all these when determining eligibility. If applicants do not fall within the guidelines, or are otherwise deemed ineligible due to asset levels or related factors, assistance will be denied.

**Every applicant is asked to call HEAR NOW to discuss eligibility.**

The application/processing fee is non-refundable and will not be returned under any circumstance.

The Starkey Hearing Foundation
HEAR NOW Program
6700 Washington Avenue South, Eden Prairie, MN 55344

**Call HEAR NOW at 1-800-328-8602 to discuss your eligibility.**
HOW TO COMPLETE THE PROCESS

1. Review the Information to Consider Before Completing the HEAR NOW Application below.

2. Find a hearing health care professional. The client is responsible for finding a hearing health care professional willing to work with them and the HEAR NOW Program. **HEAR NOW does not provide a list of hearing health care professionals or make referrals to practitioners.** Check the listings in your local phone book under “Audiologists” and/or “Hearing Aids” and call to ask if they are a HEAR NOW provider. If they are a provider, ask if they can take you on as a new client.

   **The client is responsible for the cost of the evaluation/assessment AND the non-refundable processing fee to HEAR NOW.** Once the aids are provided, the client is responsible for the purchase of batteries, purchase of Loss and Damage coverage if desired, and the purchase of extended warranty coverage for the aids.

3. Review Final Checklist for steps and documentation needed. **Please send ALL application materials at the same time to:**

   The Starkey Hearing Foundation
   HEAR NOW Program
   6700 Washington Avenue South
   Eden Prairie, MN 55344-3405

   Applications are processed as they are received. **Once you mail your application, please wait at least 6 weeks before you call for a status check.**

INFORMATION TO CONSIDER BEFORE COMPLETING THE HEAR NOW APPLICATION

1. Income Guidelines: For 48 contiguous states and D.C. ONLY. To obtain guidelines for Alaska and Hawaii, please call 800-328-8602. All income figures are NET. NET means the amount received by all those in the household.

<table>
<thead>
<tr>
<th>Size of Family unit</th>
<th>HEAR NOW Income Guideline</th>
<th>Size of Family unit</th>
<th>HEAR NOW Income Guideline</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>$18,403</td>
<td>5</td>
<td>$43,493</td>
</tr>
<tr>
<td>2</td>
<td>$24,675</td>
<td>6</td>
<td>$49,766</td>
</tr>
<tr>
<td>3</td>
<td>$30,948</td>
<td>7</td>
<td>$56,039</td>
</tr>
<tr>
<td>4</td>
<td>$37,221</td>
<td>8</td>
<td>$62,311</td>
</tr>
</tbody>
</table>

   **NOTE:** For family units with more than 8 members, add $5,500 for each additional member.

2. Application and Order Processing Fee: $100 for one (1) aid OR $200 for two (2) aids.

3. In determining eligibility, HEAR NOW considers the following: all available funds, assets and hearing loss.
   a. **Household Size** (Household is defined as the number of people financially dependent on each other).
   b. **Net Monthly or Annual Income** from all in the household who have income. **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
      - Checking
      - Money Market Accounts
      - Annuities
      - IRA/401(k)
      - Life Insurance
      - Savings
      - CDs
      - Stocks/Bonds
      - Burial Accounts

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

All items create a complete application. Missing items will delay the process.

DO NOT SEND ORIGINAL DOCUMENTS; THEY WILL NOT BE RETURNED.

- Complete pages 4, 5, and 6 – signature required on page 6
- Provide proof of income from all sources (NET income for current year)
- Send copies of all pages of bank statements (all accounts) for the most recent 9 months
- Find a hearing health care provider willing to work with HEAR NOW
- Submit Client Data Sheet (page 9) completed and signed by hearing health care provider
- Send current audiogram (less than 9 months old) obtained from the hearing health care provider
- Complete medical clearance (Page 10) release (signed by primary physician) or waiver (signed by the client)
- Send processing fee of $100 per hearing aid requested

This should be in the form of a MONEY ORDER made out to STARKEY HEARING FOUNDATION

The processing fee is a NON-REFUNDABLE fee. CHECKS ARE NOT ACCEPTED.

- Provide the most recent copy of all credit card statements you have
- Submit most recent statement for all CDs, Money Market Accounts, Burial Accounts, IRAs, 401Ks, Annuities, Stocks and/or Bonds you hold
- Send copy of subsidized housing approval notice (if applicable)

**Additional information may be needed after initial review of application is completed

HEAR NOW reserves the right to change criteria at any time without prior written notice.

Mail all these items at the same time to:

The Starkey Hearing Foundation
HEAR NOW Program
6700 Washington Avenue South, Eden Prairie, MN 55344
GENERAL INFORMATION

(Please Print Clearly)

Date: ______________________

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 financially dependent on each other)

Mailing Address:

Street ____________________________________________ Apt. # ____________

City ____________________________ County ____________________________ State ________ Zip ____________

Home Phone: ________________ Work Phone: ________________

If 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: ____________________________________________

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.)

Applicant:

A. ____________________________________________ $ ______________________ Month or Year (circle one)

B. ____________________________________________ $ ______________________ Month or Year (circle one)

Spouse/Other:

C. ____________________________________________ $ ______________________ Month or Year (circle one)

D. ____________________________________________ $ ______________________ Month or Year (circle one)
ADDITIONAL INFORMATION:

Applicant Name: ________________________________

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

Do you currently have: 

- Checking Account [ ] Yes [ ] No If yes, provide all pages of 9 months of current bank statements
- Savings Account [ ] Yes [ ] No If yes, provide all pages of 9 months of current bank statements
- Credit Card [ ] Yes [ ] No If yes, provide most recent statement
- CD(s) [ ] Yes [ ] No If yes, provide most recent statement
- Stocks/Bonds [ ] Yes [ ] No If yes, provide most recent statement
- Annuity [ ] Yes [ ] No If yes, provide most recent statement
- IRA / 401K [ ] Yes [ ] No If yes, provide most recent statement
- Money Market Account [ ] Yes [ ] No If yes, provide most recent statement
- Burial Account [ ] Yes [ ] No If yes, provide most recent statement
- Do you live in subsidized housing? [ ] Yes [ ] No If yes, provide documentation of approval notice and rent amount

If you own your home, how much are your property taxes? ____________________________ Send current statement.

Are you a Medicaid recipient? [ ] Yes [ ] No

All applicants are asked to call Hear Now to discuss eligibility for the program. Call 800-328-8602.
HOUSEHOLD INFORMATION:

Household is defined as all those who are financially dependent on each other.

Number in Household: ________________

List names of individuals in household who are financially dependent on each other (i.e., If Minor, list Parent(s); list Dependent(s); list Spouse; list Relative; list Friend, etc.).

<table>
<thead>
<tr>
<th>Name</th>
<th>Age of Person</th>
</tr>
</thead>
<tbody>
<tr>
<td>______________________</td>
<td>--------------</td>
</tr>
<tr>
<td>______________________</td>
<td>--------------</td>
</tr>
<tr>
<td>______________________</td>
<td>--------------</td>
</tr>
<tr>
<td>______________________</td>
<td>--------------</td>
</tr>
<tr>
<td>______________________</td>
<td>--------------</td>
</tr>
</tbody>
</table>

Employment Status:  
Employed  [ ]
Other   [ ]
Retired [ ]

Name of Current Employer: ________________________________

Phone: __________________________ How long have you been employed there? __________ (Years/Months)

RELEASE OF INFORMATION

I understand the information I submit to HEAR NOW concerning my annual income, family size, family resources, insurance, medical history and all financial information are subject to verification by HEAR NOW and/or their agents. This verification will be done by phone, letter, e-mail 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.

I understand the non-refundable application/processing fee will not be returned to me under any circumstance.

Applicant Name: ___________________________  Spouse’s Name: ___________________________

Date of Birth: ___________________________  Date of Birth: ___________________________

Applicant Signature: ______________________  Spouse’s Signature: ______________________

(If Minor, Parent/Guardian signature required)

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.
Dear Hearing Health Care Provider:

HEAR NOW, the US program of the Starkey Hearing Foundation, is committed to helping low income individuals who lack the resources to obtain needed hearing aids. Because the program works only with the help of generous, dedicated practitioners who care about the members of their community, your support of HEAR NOW clients is deeply appreciated. Practitioners are asked to waive their customary fees for fitting and follow-up for the first year of warranty coverage. You may assess your normal fee for the initial evaluation.

While interested practitioners are asked to donate their time and services to do the fitting and follow-up for the first year of warranty coverage, HEAR NOW provides the hearing aids to be fitted in your office. The Client Data Sheet (CDS) is an integral part of your client’s application. An applicant’s file is not complete without the CDS (page 9). The application is reviewed when the Client Data Sheet, audiogram, Client Application and support documents are received in the HEAR NOW office. It is helpful if all documents are sent at the same time.

Practitioners willing to waive their customary fees for fitting and follow-up for the first year and are licensed to dispense hearing aids in their state are eligible to work with the program. It is necessary to have practitioner licensure information on record at HEAR NOW. Please provide this information on the Client Data Sheet for each client. If the client is approved for hearing aid assistance you will be contacted by HEAR NOW with instructions regarding the ordering process. It is preferable that impressions are kept in the practitioner’s office until authorization to order aids/earmolds is received from HEAR NOW.

HEAR NOW provides the hearing aids and earmolds when BTE aids are chosen. The hearing aids may be ITE, ITC, BTE, Body and Bone-Conduction type instruments. CICs are not on the menu of the program. All instruments provided through the program come with a one-year warranty for repair. It is strongly recommended that extended warranty coverage be purchased through the practitioner’s office. If you have questions regarding aids and options, please call HEAR NOW at the number below.

The program has grown significantly over the years. It is expected that as the program continues to be discovered, the requests for assistance will continue to grow. Clients are asked to wait at least five (5) years before re-applying for new hearing instruments.

HEAR NOW reserves the right to change eligibility criteria at any time without written notice.
HEAR NOW Program - Application for Hearing Aid Assistance

CLIENT DATA SHEET – MEDICAL/AUDIOLOGICAL INFORMATION

To be completed by the provider FITTING AIDS FOR CLIENT (Please Print Clearly)

Name of Client: __________________________________________________________________________ Date of Birth: __________________________

PLEASE ATTACH: Air and Bone Conduction Audiogram, SRTs, MCLs and UCLs

Is the client currently aided? ☐ YES ☐ NO  If yes, list make/model and how old? __________________________________________

Number of aids requested: ______________

If fitting only one (1) ear, which ear are you fitting? (check one) ☐ LEFT ☐ RIGHT

Why? _____________________________________________________________________________________________

Circle your choice of style (CICs are not an option):

Custom BTE # of earmolds (if using BTEs) ______ BODY Bone Conduction

Color of casing (check one): ☐ Beige ☐ Brown ☐ Dark Brown ☐ Gray ☐ Pink Other: __________________________

Suggested Starkey BTE Aid: _______________________________________________________________________

Technology Requested: (check one) ☐ Programmable Digital ☐ Non-Programmable Digital

If you are fitting digital BTEs, do you need any of the following? Please check your needs: ☐ Software ☐ Cables ☐ Boots

I agree to become an associate of HEAR NOW for this client. I agree to provide services in accordance with state/federal guidelines. I understand that associates who receive hearing aids from HEAR NOW for their client agree to provide the services related to the fitting and follow-up without charge to the client for the first year of warranty coverage. HEAR NOW does not ask associates to waive any of their customary evaluation/hearing assessment fees. Charges related to the initial hearing evaluation are the client’s responsibility.

PLEASE COMPLETE THIS SECTION FOR EACH CLIENT. THANK YOU.

Starkey Ship to Account #: __________________________ OR Audibel Ship to Account #: __________________________

Name of Professional: ___________________________________________________________________________

Name of Business: _______________________________________________________________________________

Address: _______________________________________________________________________________________

City: __________________________________________ State: ________ Zip: ________________

Phone: ____________________________ Fax: __________________________

State Licensure/Registration #: __________________________

ASHA # __________________ F-AAA # __________________ IHS # __________________ BC-HIS # ________________

☐ I do not have my CCC-A. Supervised by: __________________________ State #: __________________________

Signature: __________________________________________________________________________ Date: ______________

E-mail _________________________________________________________________________________________
One of the following MUST be completed and submitted with the application.

MEDICAL CLEARANCE FOR HEARING AID USE

To be signed by client’s Primary Physician

Date: ______________________

Patient Name (please print): ____________________________________________

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

Physician Name (please print): ____________________________________________

Physician Signature: _____________________________________________________

OR

WAIVER OF MEDICAL CLEARANCE FOR HEARING AID USE

To be completed and signed by the client

Date: ______________________

Client 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.

Client Signature: ______________________________________________________