



APPLICATION

The H.E.A.R. Project was established to provide supplemental funding toward the purchase of hearing aids, repairs, earmolds and accessories for hearing impaired children ages birth to 18 who do not qualify for Medicaid. If your child is receiving Medicaid, please contact your caseworker. To determine Medicaid eligibility, call (303) 866-6010.

The maximum award is \$1000 or \$500 per hearing aid. If an award of \$200 or less is needed, please use the short application form available at www.coloradoaudiology.org.

Financial Guidelines

Family Size	Annual Household Income
2	\$55,000
3	\$66,000
4	\$77,000
5	\$82,500
6	\$88,000
Each additional	\$ 5,500

Family Size: _____ Total Family Income: _____ Date: _____

Child's Name: _____ Birthdate: _____

Male: _____ Female: _____ Parents/Guardians Names: _____

Address: _____

Home phone: () _____ Work phone: () _____

Ethnicity: _____ **Optional**-This information is used only to assist the H.E.A.R. Project in obtaining grant funding.

What assistance is requested? _____ Amount: _____

Is your child receiving Medicaid? _____ Yes _____ No

Do you have Health Insurance? _____ Yes _____ No

If yes, does your Health Insurance Company provide hearing aid coverage _____ Yes _____ No

Have you applied for other funding? Yes ___ No ___ If yes, where and what was the result?
This will NOT affect your H.E.A.R. Project award.

INCOME

List all sources of income (i.e. salary, social security, alimony, child support, investments, etc.)

- 1. _____ \$ _____
- 2. _____ \$ _____
- 3. _____ \$ _____
- 4. _____ \$ _____

Do you currently have a checking account? Yes No Savings Account? Yes No

Parent/Guardians employment status: Employed _____ Retired _____ Other _____

1) PARENT:

Name of Employer: _____ Phone: () _____

How long have you been employed there? _____

2) PARENT:

Name of Employer: _____ Phone: () _____

How long have you been employed there? _____

Monthly Medical Expenses Medical \$ _____ Medications \$ _____

Health Insurance: \$ _____ Dental: \$ _____ Speech Therapy: \$ _____ Other: \$ _____

Estimated monthly living expenses:

Rent/Mortgage: _____ Utilities: _____ Credit Cards: _____
Food: _____ Entertainment: _____ Insurance: _____
Childcare: _____ Autos: _____ Miscellaneous: _____

Audiologic Data Information:

Audiologist fitting the amplification: _____

Address: _____

Phone: _____ Tax I. D. #: _____

Email Address: _____

Name and phone number of Educational Audiologist: _____

Type and degree of hearing impairment: _____

The age at which the hearing loss was identified: _____

Is child currently wearing amplification? Yes/No

If yes, what is the manufacturer and age of the amplification? _____

**THE FOLLOWING ADDITIONAL INFORMATION IS REQUIRED.
PLEASE SEND COPIES, DOCUMENTS WILL NOT BE RETURNED:**

Parents:

1. Letter from parents stating request and describing any unusual circumstances or financial hardship.
2. Documents which confirm your reported income (i.e.- pay stubs, last years federal income tax return and/or all W-2's) or employer's verification of income. If these cannot be provided a letter from the family and dispensing audiologist verifying income to the best of their ability must be provided.
3. Copies of your most recent bank statements (both savings and checking).
4. Photo of your child.
5. Medical records. OPTIONAL: Please send these only if you want unusual medical expenses to be considered as part of your application.

Dispensing Audiologist:

1. Letter stating the cost of the device and why it is needed.
2. Patient's audiogram.

PLEASE BE SURE TO INCLUDE ALL INFORMATION. INCOMPLETE APPLICATIONS WILL BE RETURNED

UNUSUAL INDIVIDUAL/FAMILY SITUATIONS WILL BE TAKEN INTO CONSIDERATION

Release of Information

I understand that the information that I have submitted is 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. This is used for fund-raising purposes. It may be removed at any time at your request.

Permission to use photo: Yes No

Parent's Name _____ Parent's Name _____

Signature _____ Signature _____

Mail or Fax to: Carolyn Wolfrum: 8823 West Warren Drive, Lakewood, CO. 80227
Phone and/OR Fax: (303) 527-1818

Please keep a copy of this application for your records. We encourage you to share this information with other funding sources. The H.E.A.R. Project will not share this information with any other organizations.

If you have questions about the H.E.A.R. Project or this application, please call:
Carolyn Wolfrum (303) 527-1818
Jill Boice (303) 863-7580