



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

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