Hearing Evaluation Services of Buffalo, Inc.
It's Good to Hear

Dr. Ann Stadelmaier Hearing Aid Fund

Financial Assistance Application

Applicant's Name: _____ Date: _____ DOB: _____

Street: _____ City: _____ State: _____ Zip: _____ Phone: _____

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

Employer: _____ Job Title: _____

How did you hear about the Dr. Ann Stadelmaier Fund? _____

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

Health Insurance ID Number: _____

Emergency Contact Name: _____ Relationship: _____ Phone: _____

Name of Audiologist/Physician: _____ City: _____ Phone: _____

Do you currently have a hearing aid(s)? **YES/NO** Which ear(s)? **LEFT/RIGHT/BOTH** How Old? ___ years 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)	☐YES ☐NO	Monthly Amount $ _____	Amount deducted for Medicare Part B: $ _____	
Supplemental Security Income (SSI)	☐YES ☐NO	Monthly Amount $ _____		
Food Stamps/Other Nutritional Support Services	☐YES ☐NO	Monthly Amount $ _____		
Pension/Retirement (all types)	☐YES ☐NO	Monthly Amount $ _____	Source of Pension:	
Veterans (VA) Benefits	☐YES ☐NO	Monthly Amount $ _____		
Disability (private or NYS)	☐YES ☐NO	Monthly Amount $ _____	Source:	
Total value of all savings, checking, CD's, money market accounts, etc.	**Send statement copy**	**Checking $_____** **Savings $ _____** **CD's $ _____** **Money Market $ _____** **Other $ _____**	Source(s):	

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TYPE OF INCOME	CHECK ONE (√)	IF YES, GIVE AMOUNT		WHO RECEIVES?
Interest from savings, checking, CD's, money market accounts, etc.	☐YES ☐NO	Yearly Amount $ _____	Source(s):	
Total value of all stocks, bonds, etc.		Stocks $ _____ Bonds $ _____	Source(s):	
Dividends from stocks, bonds, securities, etc.	☐YES ☐ NO	Yearly Amount $ _____	Source(s):	
Does anyone in the household work? If yes, submit wage stubs for the past four (4) weeks	☐YES ☐ NO	Weekly Amount (before deductions) $ _____	Employer:	
Is there any other income from any other source?	☐YES ☐ NO	Yearly Amount $ _____	Source(s):	
Rental Income (apartment, garage space(s), land, etc.)	☐YES ☐ NO	Monthly Amount $ _____	Type of Rental:	
Room/Board (received)	☐ YES ☐ NO	Monthly Amount $ _____	Name:	
Workers Compensation	☐YES ☐ NO	Weekly Amount $ _____		
Unemployment Benefits	☐YES ☐ NO	Weekly Amount $ _____		
Contribution (from someone outside household)	☐ YES ☐ NO	Weekly Amount $ _____	Name of Contributor:	
Child Support Received	☐ YES ☐ NO	Court-Ordered Weekly Amount $ _____	Source:	

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

Please mail to: 337 Cleveland Drive Suite 6 Buffalo, NY 14215 Attention: Stephanie Hilbert **7/13/16**