



Hear to help

Hearing aid assistance programs through the Dr. Ann Stadelmaier Hearing Aid Fund



Our staff of Board Certified Doctors of Audiology are at the top of their field as clinicians, researchers and university instructors and are entrenched in the local medical community. We diagnose, counsel and provide solutions for individuals with hearing, tinnitus and balance problems throughout Western New York. Our mission as a non-profit organization is to improve lives through personal and honest hearing healthcare. Our non-commissioned staff works to provide you with the very best solution to fit your lifestyle and budget and to keep you connected to what matters most in life; friends and family.

It's Good to Hear!

Hearing Evaluation
Services of Buffalo, Inc.



(716) 833-4488

HESofBuffalo.org

AMHERST

4600 Main Street
Amherst, NY 14226

ORCHARD PARK

4063 N. Buffalo Road
Orchard Park, NY 14127

TONAWANDA

2545 Sheridan Drive
Tonawanda, NY 14150

WILLIAMSVILLE

2733 Wehrle Drive
Williamsville, NY 14221

Dr. Ann E. Stadelmaier (1953-2006), an audiologist, Executive Director of Hearing Evaluation Services of Buffalo and Kenmore Lion passed away after a long battle with cancer in August 2006. Dr. Stadelmaier was dedicated to helping hearing-impaired individuals meet their hearing needs regardless of their ability to pay. It was her final wish that a fund be established to help those in need achieve their hearing goals.

Mission: The Dr. Ann Stadelmaier Hearing Aid Fund has been established to provide hearing assistance to individuals in need who cannot otherwise afford these services in the Erie, Niagara, Chautauqua and Cattaraugus Counties.

Eligibility Criteria: Eligibility is based on financial and audiological needs and is only available to individuals **who do not currently have a functioning hearing aid and/or full hearing aid coverage** through their insurance carrier. If you are unsure about your eligibility, call 716-544-6210 to speak with our Insurance Specialist. To apply for funding the applicant must submit the following:

- Financial assistance application along with a copy of their most recently filed IRS tax return
- Social Security Administration statement
- Financial documentation including current bank statements for each household member
- Copy of a recent audiogram (within one year)

Failure to submit all documents will result in a delay in processing the application.

The Dr. Ann E. Stadelmaier Case Review Committee will determine if eligibility criteria are met. Each applicant will receive a letter from the committee following the review.

Approved applicants will receive the following:

- One new digital hearing aid in a full-shell, half-shell, canal or behind-the-ear style. An ear mold is included for behind-the-ear hearing aid users.
- Telephone coils (T-Coils) are available on behind-the-ear hearing aids for those who have difficulty hearing over the phone.
- A one-year factory repair warranty.
- Hearing aid evaluation, fitting and follow-up (for one year) at Hearing Evaluation Services of Buffalo, Inc., unless otherwise directed by the review committee.

Patient Responsibility:

- Once the approval letter is received, the applicant is to contact Hearing Evaluation Services (716) 833-4488 to schedule an appointment for the Hearing Aid Evaluation, unless other arrangements have been approved by the review committee.
- Based on ability to pay, the applicant may be responsible for a one-time \$150 dispensing fee which covers all office visits within the first year.
- Your appointment will be scheduled at the Williamsville, Amherst, Orchard Park or Tonawanda office locations.

**Hearing Evaluation Services realizes that hearing is the basis for all human communication.
It is our wish is to assist those in need.**



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)	<input type="checkbox"/> YES <input type="checkbox"/> NO	Monthly Amount \$ _____	Amount deducted for Medicare Part B: \$ _____	
Supplemental Security Income (SSI)	<input type="checkbox"/> YES <input type="checkbox"/> NO	Monthly Amount \$ _____		
Food Stamps/Other Nutritional Support Services	<input type="checkbox"/> YES <input type="checkbox"/> NO	Monthly Amount \$ _____		
Pension/Retirement (all types)	<input type="checkbox"/> YES <input type="checkbox"/> NO	Monthly Amount \$ _____	Source of Pension:	
Veterans (VA) Benefits	<input type="checkbox"/> YES <input type="checkbox"/> NO	Monthly Amount \$ _____		
Disability (private or NYS)	<input type="checkbox"/> YES <input type="checkbox"/> 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.	<input type="checkbox"/> YES <input type="checkbox"/> NO	Yearly Amount \$ _____	Source(s):
Total value of all stocks, bonds, etc.		Stocks \$ _____ Bonds \$ _____	Source(s):
Dividends from stocks, bonds, securities, etc.	<input type="checkbox"/> YES <input type="checkbox"/> NO	Yearly Amount \$ _____	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 (before deductions) \$ _____	Employer:
Is there any other income from any other source?	<input type="checkbox"/> YES <input type="checkbox"/> NO	Yearly Amount \$ _____	Source(s):
Rental Income (apartment, garage space(s), land, etc.)	<input type="checkbox"/> YES <input type="checkbox"/> NO	Monthly Amount \$ _____	Type of Rental:
Room/Board (received)	<input type="checkbox"/> YES <input type="checkbox"/> NO	Monthly Amount \$ _____	Name:
Workers Compensation	<input type="checkbox"/> YES <input type="checkbox"/> NO	Weekly Amount \$ _____	
Unemployment Benefits	<input type="checkbox"/> YES <input type="checkbox"/> NO	Weekly Amount \$ _____	
Contribution (from someone outside household)	<input type="checkbox"/> YES <input type="checkbox"/> NO	Weekly Amount \$ _____	Name of Contributor:
Child Support Received	<input type="checkbox"/> YES <input type="checkbox"/> NO	Court-Ordered Weekly Amount \$ _____	Source:

I fully understand that the Dr. Ann E. 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: 2733 Wehrle Drive Suite 200 Williamsville, NY 14221
Attention: Stephanie Hilbert