DALLAS HEARING FOUNDATION

BRINGING SOUND TO LIFE

Attached is the application for assistance through the Dallas Hearing Foundation. The **ENTIRE** application must be completed and ALL documents requested must be included or your application will not be processed.

Please note that DHF must receive any documents we deem necessary to fully assess your financial situation. This primarily includes you or your families last 2 filed IRS tax returns. If you do not file a tax return, we must have a letter of explanation why together with full disclosure of all sources of income for the past 2 years.

If you have insurance, Medicare or Medicaid, you must include this information. Having these does not disqualify you for assistance, but this information must be provided, including a copy of the card.

Please include a copy of your driver's license, ID card or passport.

You MUST include a copy of your most recent hearing test. For children, in addition to the hearing test, you must provide a letter of medical clearance from the doctor who diagnosed the hearing loss. If you do not have a hearing test, you are responsible for obtaining a professionally performed hearing test to include with the application. Upon request, Jennifer Clark can provide a list of local providers who perform hearing testing, but it will be your responsibility to contact the provider for appointments and fees.

If you are applying for assistance for a cochlear implant, you must also include all medical records and evaluations related to the applicant's hearing loss. The board must have this information to review your application. If this information does indicate that a cochlear implant may be an appropriate treatment, you will be asked to then obtain an MRI of the brain and inner ears (if not already done) and have the CD of the scan mailed to DHF. Final determination can then be completed.

Due to the volume of requests received by the Dallas Hearing Foundation, applications that are incomplete or do not include all of the required documents will not be processed.

If you have any questions while completing the forms, do not hesitate to contact Jennifer Clark at jennifer.clark@dallashearingfoundation.org or 972-424-7711.

These items may be scanned and emailed, faxed or sent through the mail to the following address:

Dallas Hearing Foundation
7777 Forest Lane, CA94 PMB 143
Dallas, TX 75230

Dallas Hearing Foundation
7777 Forest Lane, C-A94 PMB 143
Phone: (972) 424-7711
Dallas, Texas 75230

STOP AND READ

Before you complete the attached application, please answer the following questions:

Do you currently have insurance? _____If so, please be sure to include this information with your application. Having insurance does not affect your eligibility to receive assistance through the Dallas Hearing Foundation. Include a copy of the front and back of the insurance card.

Do you have Medicare or Medicaid? _____If so, please be sure to include this information with your application along with a copy of the front and back of the card. Having Medicare or Medicaid does not affect your eligibility to receive assistance through the Dallas Hearing Foundation.

Who referred you to the Dallas Hearing Foundation?_____

Have you worked with DARS/TWC in the past?_____

Have you had a recent hearing test? _____If so, please include this with your application.

Do you have an email address? If so, please include this here:_____

When you submit the application, please make sure you include ALL of the requested documents or your application will be returned.

You MUST include the completed application, a copy of your driver's license or ID card and verification of income. You must include your IRS tax returns for the last two years along with W-2's for the last two years. If there is anyone over 18 living in the house with the applicant, their income information must also be provided.

If applicant is on a fixed income, a copy of a statement from Social Security or the source of the income is required. This can be an end of year statement, but we will need one for the last two years. All income must be included with the application.

If you have a question about the application, please contact Jennifer Clark at 972-424-7711 or jennifer.clark@dallashearingfoundation.org.

Dallas Hearing Foundation

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APPLICATION FOR SLIDING SCALE FEES - ADULT

To be eligible for our Sliding Scale (reduced) Fee, you must complete and sign this application. You will also need to enclose a copy of your driver's license or photo ID card and verification of income. Verification of income must include: IRS tax returns,OR W-2's from the past two years, OR paycheck stub from each of the past two years, OR copies of any government benefits statements for the past two years, if that is your income. This information must be furnished for all income earning members of the applicant's immediate family if they live with the applicant. After review and verification of this information, you will be notified of the fee that will be applicable to this patient.

PATIENT NAME_____ **BIRTHDATE** ___/___/___

Patient's address_____

Area code and phone number_____

E-mail address_____

Patient's Medicaid # _____ SSI_____ AFDC_____ MAO_____

Patient's Social Security number _____

Patient's annual income or public assistance _____

Patient's State of residence _____ Patient's Country of citizenship_____

If you have had a recent hearing test, please attach a copy to the application

FINANCIAL STATEMENT

All items must be completed or this form will be returned without action.

1) How many people live in the household with the patient? _____

2) What is the net monthly income (take-home pay, after taxes) from all sources in the household, including public assistance? _____

3) What are the total monthly expenses for the household (including: house payment, electricity, gas, water, laundry, groceries, gasoline and monthly payments on loans or accounts)? _____

If greater than the amount on Line 2, please explain _____

4) What is the total indebtedness for the household (money owed to banks, finance companies and charge accounts? _____

5) What is the total value of all property (including house, land and automobiles)? _____

6) Are there any other sources of money to pay for the hearing assistance and/or other services (private insurance, Medicaid, etc.)? _____

7) Is the family receiving any type of public assistance? Yes _____ No _____

Food stamps? Yes _____ No _____ Rent subsidy? Yes _____ No _____

Please provide the following information with regard to the patient's adult children:

Name _____

Address _____

Area code and phone number _____

Name _____

Address _____

Area code and phone number _____

Name _____

Address _____

Area code and phone number _____

Name _____

Address _____

Area code and phone number _____

In addition, please provide proof of income, which must include IRS tax returns and W-2's from the past two years, and a paycheck stub from each of the past two years, <u>for each of the patient's adult children listed above.</u>

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Please specify the type of assistance the patient needs (cochlear implant, hearing aid, medical treatment):

_____

I certify that the above information is, to the best of my knowledge, true and correct and agree to provide current proof of income whenever requested to do so. I understand that the fee determined for this patient is subject to change upon a change in my income or a change in the Sliding Fee Scale. I further understand that failure to provide adequate proof of income will make me ineligible for the Sliding Scale Fee and the fee for this patient will then automatically become DALLAS HEARING FOUNDATION'S fee. I have no insurance covering this patient. If approved for assistance, I understand that it is my responsibility to provided updated financial information each calendar year.

_____ _____

Signature of Patient/Applicant Date Signed

Dallas Hearing Foundation
Waiver and Release of Liability

Section 1. Assumption of Risk, Release of Liability and Indemnification

As an Applicant for funding from the Dallas Hearing Foundation, I understand that the Dallas Hearing Foundation is a nonprofit charitable organization that provides funding for hearing services and devices for individuals in financial need, but does not guarantee that each applicant will receive funding.

I understand that the Dallas Hearing Foundation does not provide medical services. Any medical services I receive will be provided by separate entities that are neither employees, agents, affiliates, or servants of the Dallas Hearing Foundation (the "Medical Entities"). The Dallas Hearing Foundation makes no assurances and bears no responsibility for services, including hearing devices, provided by the Medical Entities.

In exchange for the value and benefit of hearing services, including hearing devices, provided by the Dallas Hearing Foundation, including any funding I may qualify for, I, HEREBY, WAIVE AND RELEASE, indemnify and hold harmless and forever discharge the Dallas Hearing Foundation and its agents, employees, officers, directors, and affiliates, of and from any and all claims, causes of action, lawsuits, damages and liability, of every kind and nature, whether known or unknown, at law or in equity, arising from, relating to or resulting from my participation in or receipt of services provided by the Dallas Hearing Foundation.

Section 2. Arbitration

I agree to resolve any and all claims, disputes or controversies arising out of or relating to my participation in or receipt of services provided by the Dallas Hearing Foundation exclusively by final and binding arbitration using a single arbitrator in Dallas, Texas pursuant to the rules of the American Arbitration Association. Arbitration shall be commenced within one (1) year from the date on which the alleged claim arose. The submission to the American Arbitration Association shall be unlimited, and any court of competent jurisdiction may enforce the arbitration award.

Section 3. Authorization

I am aware that this Waiver and Release of Liability is a legally binding agreement between the Dallas Hearing Foundation and me that affects my legal rights. This Waiver and Release of Liability contains the entire agreement between the parties, and I have not relied upon any oral representations, statements or inducements other than what is set forth in writing in this Waiver and Release of Liability.

This Waiver and Release of Liability is governed by the laws of the State of Texas and is intended to be as broad and inclusive as is permitted by that law. If any provision of this Waiver and Release of Liability is deemed invalid or unenforceable by an arbitrator or a court of competent jurisdiction, the remaining provisions will continue to be fully effective.

This Waiver and Release of Liability must be signed by adult Applicants or by a parent or guardian on behalf of minor Applicants before participation in or receipt of services.

CONTINUE TO PAGE 2

PLEASE READ CAREFULLY AND SIGN IN THE PRESENCE OF A NOTARY PUBLIC

I am of lawful age and legally competent to sign this Waiver and Release. I have read and fully understand the terms of this Waiver and Release, and I am signing this document voluntarily, without inducement, and of my own free will.

Signature of Applicant_____ Date _____

Printed Name _____

SUBSCRIBED AND SWORN TO BEFORE ME this ____ day of _____, 20__.

_____
Notary Public, State of _____

PARENT OR GUARDIAN CONSENT (If applicant is under age 18): I am the parent of legal guardian of the participant and I agree that the foregoing Waiver and Release of Liability shall be binding on me and the minor applicant.

Signature of Parent/Guardian_____ Date _____

Printed Name _____

SUBSCRIBED AND SWORN TO BEFORE ME this ____ day of _____, 20__.

_____
Notary Public, State of _____