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

Atencion:

Before you complete the attached application, please answer the following questions:
Antes de completer la solicitud adjunta, por favor responda ala siguientes preguntas.

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.

Tienen seguro?_____SI si, porfavor incluya la informacion con su solicitud. El tener seguro no afecta su eligibilidad para recibir asistencia a traves de Dallas Hearing Foundation. Por favor incluya una copia de los dos lados de la tarjeta de seguro.

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.

Tiene Medicare o Medicaid?_____Si si, por favor incluya la informacion con una copia de ambos lados de la tarjeta. El tener Medicaid or Medicare no afecta su elegibilidad de Dallas Hearing Foundation.

Who referred you to the Dallas Hearing Foundation?_____
Quien lo refirio a Dallas Hearing Foundation?_____

Have you worked with DARS/TWC in the past?_____
Ha trabajado para DARS/TWC en alguna occasion?

Have you had a recent hearing test? _____If so, please include this with your application.
Cuando fue su prueba auditiva mas reciente? Por favor incluyalo en su solicitud.

Do you have an email address? If so, please include this here:_____
Tiene correo electronico? Por favor incluya su direccion:

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

Cuando entregue la solicitud, por favor incluya TODOS los documentos requeridos o su solicitud sera retornada.

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. DEBE incluir la solicitud completada con los documentos de identificacion, verificacion de sueldos y copias de sus impuestos de los ultimos 2 anos. Si alguien mayor de la edad de 18 anos de edad, debe incluir el sueldo si aun vive en casa.

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. Si el solicitante tiene recursos limitados, una copia de los ingresos del Seguro Social seran requeridos. Esto puede ser un document annual pero lo necesitamos de los ultimos dos anos.Todo ingreso debe ser incluido.

Dallas Hearing Foundation_____

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

APPLICATION FOR SLIDING SCALE FEES – ADULT

Solicitud para escala de pago: Adulto

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 drivers license or photo ID card and verification of income. Verification of income must include: IRS tax returns,W-2's from the past two years, a paycheck stub from each of the past two years, and copies of any government benefits statements for the past two years. This information must be furnished for all income earning members of the applicant's immediate family. After review and verification of this information, you will be notified of the fee that will be applicable to this patient.

Para sere legible para nuestra escala de pago o pago reducido; debe completer esta solicitud. Debe 3eguro3 incluir una opia de su licencia de manejo o identificacion con foto, y verificacion de ingresos. Esta verificacion debe incluir impuestos pagados, reembolso de impuesto, W-2 de los ultimos 24 meses, un copia de pago presente y anterior. Incluido debe ser las ganacias de todas los miembros de familia que habitan con el paciente. Despues de revision y verificacion de tal informacion, seran notificados de la escala de pago que le correspondera al paciente.

PATIENT NAME__nombre del paciente_____ **BIRTHDATE** ___/___/___ fecha de 3eguro3nto

Patient's address direccion del paciente_____

Area code and phone number_area y numero _____

E-mail a**ddress** Correo Electronico_____

Patient's Medicaid # # Medicaid_____ SSI_____ AFDC_____ MAO_____

Patient's Social Security number numero de 3eguro social_____Patient's annual income or public assistance _Ingresos del paciente incluyendo asistencia publica_____

Patient's State of residence Estado de residencia_____ Patient's Country of citizenship Pais de Origen_____

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.Todo debajo debe ser completado o no sera procesado

1) How many people live in the household with the patient? _____Cuantas personas habitan en el hogar?_____

2) What is the net monthly income (take-home pay, after taxes) from all sources in the household, including public assistance? _____Cual es su ingreso total despues de impuestos, incluyendo asistencia publica e ingresos de todos en el hogar._____

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)? _____
Cuales son los gastos mensuales, incluyendo renta, electricidad, gas, agua, comida, transporte, prestamos etc.?_____
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? _____Cual es su deuda total?_____

5) What is the total value of all property (including house, land and automobiles)? Cual es el valor total de su propiedad incluyendo autos, casa, terrenos.. _____

6) Are there any other sources of money to pay for the hearing assistance and/or other services (private insurance, Medicaid, etc.)?_____
Hay otros recursos para la asistencia de audiocion o otros servicios como Medicaid, seguro, etc.? _____

7) Is the family receiving any type of public assistance? Recibe la familia asistencia publica? Si Yes _____ No _____

Food stamps? Estampillas? Si Yes _____ No _____ Rent subsidy? Ayuda con renta? SI Yes _____ No _____

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

Name _____

Nombre_____

Address _____

Direccion_____

Area code and phone number _____

Numero telfonico con el codigo del area_____

Name _____

Nombre_____

Address _____

Direccion_____

Area code and phone number _____

Numero telefonico con codigo del area_____

Name _____

Nombre_____

Address _____

Direccion_____

Area code and phone number _____

numero telefonico con codigo del area_____

Name _____

Nombre_____

Address _____

Direccion_____

Area code and phone number _____

numero telefonico con codigo del area_____

En adicion, por favor prove comprobante de ingresos, tal como informacion del IRS, Impuestos, W-2 de los ultimos 24 meses y una copia de su sueldo de los dos ultimos anos.

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>

****

Por favor especifique el tipo de asistencia que el paciente necesita (implante cochlear, audifonos, tratamiento medico, etc.)

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

_____

Certifico que la informacion esta hecha bajo lo major de mis conocimientos y que son correctos y ciertos y estoy dispuesto en proporcioanr comprobante de pagos, sueldos o cambios en la escala de pagos. Tambien reconozco que falta de tal comprobante de ingresos me haran inelegibles para los pagos a escala y los cobros conscecuentes automaticamente seran parte de la fundacion de DALLAS HEARING FOUNDATIONS cobros.

No tengo seguro para cubrir este paciente. Si soy aprovado para la asistencia, comprendo que es mi responsabilidad de proveer informacion financiera anualmente.

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
Firma de recipient o solicitor

Date Signed
Fecha

Mande la aplicacion completada, copia de licencia o identificacion y verificacion de sueldos a:
Mail completed application, copy of drivers license or ID card, and verification of income to:
Dallas Hearing Foundation 7777 Forest Lane, C-A94 PMB 143 Dallas, TX 75230

Dallas Hearing Foundation
Waiver and Release of Liability
Renuncia yExculpacion de Obligaciones

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.
Primera Seccion: Asuncion de Riesgo y Exculpacion de Obligaciones e Indemnizacion: Como solicitante para recursos del Dallas Hearing Foundation, Comprendo que Dallas Hearin Foundation es una organizacion de caridad y sin profito que provee financiamiento para los servicios y aparatos auditivos para individuos con necesidad economica pero no garantiza que cada solicitante reciba financiamiento**.**

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.
Comprendo que Dallas Hearing Foundation no prove servicios medicos. Cualquier servicio medico que recibire sera proveido por entidades separadas a Dallas Hearing Foundations, que no sean afiliados,agentes, empleados o servidores de Dallas Hearing Foundation. Dallas Hearing Foundation no hace aseguranzas ni toma responsabilidades por los aparatos auditivos proveidos por Entidades Medicas.

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.
A cambio del valor y beneficio de los servicios de audicion, incluyendo aparatos auditivos proveidos por Dallas Hearing Foundation, e incluyente de recursos por las cuales podria qualificar, **yo renuncio, libero y aseguro y para siempre librare** a los agentes, empleados, oficiantes, directores, y afiliados de Dallas Hearing Foundation de cual quier forma de causas de accion, reclamos, daños y demandas, conocidas o no conocidas legalmente or en la justicia, resultados or relacionados con mi participacion o recibo de los servicios proveìdos por 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.
Seccion 2: Arbitraje
Estoy dispuesto en resolver reclamos, disputas o controversias resultadas de mi participacion o del recibo de servicios proveidos por el Dallas Hearing Foundation exclusivamente por el contrato de Arbitracion en Dallas, Texas, siguiendo las reglas de La Asociacion Americana de Arbitraje (American Arbitration Association). Arbitracion comenzara un (1) año de la fecha en cual el reclamo comenzo Submision al American Arbitration Association sera inlimitable y la corte de jurisdiccion podra enforzar el laudo arbitral**.**

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.
Seccion 3: Autorizacion:
Estoy conciente que este extension y exculpacion de obligaciones es un acuerdo entre yo y Dallas Hearing Foundation y que es Legal y que es un contrato vinculante y que afecta mis derechos. Esta exoneracion de obligaciones contiene el acuerdo complete entre los grupos y no he dependido de representaciones, comentarios o impreciones fuera de la informacion dada por escrita en este document de Exoneracion de Obligaciones.

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.
Estoy consciente que esta extension y exculpacion de liabilidades esta governado por las leyes del Estado de Texas y que la intencion es amplia y permitida por la ley. Si alguna provision de este documento de exoneracion de obligaciones resulta ser inenforzable or invalida por el arbitro o la corte de jurisdiccion, las provisiones restantes continuaran a ser completamente efectivas.

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.
Esta extension y exculpacion de liabilidades debe ser firmada por el solicitante adulto o uno de los padres o guardians del menor antes de poder participar or recibir los servicios

CONTINUE TO PAGE 2

Siga a la siguiente pagina:

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

Por favor lea con cuidado y firme en prescencia de un Notario Publico

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.

Soy de edad legal para firmar este formulario de exculpacion y liberacion de informacion. Estoy firmando este documento libremente, en mi propia voluntad,y sin presion extererna.

Signature of Applicant_____ Date _____

Firma _____ Fecha_____

Printed Name _____

Nombre escrito en letra de Molde_____

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

Firmado y Jurado ante mi, este_____dia de_____, 20_____.

Notary Public, State of _____

Notario Public del Estado de: