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 DAR/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 **ALL** 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 – CHILD

Solicitud para escala de pagos: Menores de Edad

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 pagos reducidos, debe llenar y firmar esta solicitud. Tambien debe incluir copias de su identificacion/licencia de manejo, y verificacion de ingresos. La verificacion de ingresos de los ultimos dos anos Incluyendo verificacion de impuestos, W-2. Esta informacion debe ser incluyente de todos los ingresos de los miembros de familia que viven en el hogar. Despues de revicion y verificacion de la informacion, seran notificados del costo que sera aplicado hacia el paciente.

PATIENT NAME_____ **BIRTHDATE** ___/___/___
Nombre del Paciente **Fecha de Nacimiento**

Patient's address_____
Direccion del Paciente

Patient's Medicaid # _____ SSI_____ AFDC_____ MAO_____
de Medicaid SSI AFDC MAO

Patient's Social Security number _____
Numero del Seguro Social del Paciente

Patient's annual income or public assistance _____
Ingresos anuales o Asistencia Publica que recibe el paciente

Patient's State of residence _____ Patient's Country of citizenship _____
Estado de residencia del Paciente Pais de Origen del Paciente

****

Full legal name of patient's father _____
Nombre Legal Completo del Padre

Father's street address or P.O. Box _____
Direccion del Padre o Caja Postal

City, State and Zip Code _____
Ciudad, Estado y codigo postal

Area code and phone number _____
Area y Numero de telefono

Father's Social Security number _____
Numero de Seguro Social del Padre

Annual income or public assistance _____

Ingresos o Asistencia Publica que recibe el Padre Anualmente

Father's State of residence _____ Father's Country of citizenship _____
Estado de Residencia del Padre Pais de Origen del Padre

****

Full legal name of patient's mother _____
Nombre Completo de la Madre del Pacient

Mother's street address or P.O. Box _____
Direccion o caja postal de la Madre del Paciente

City, State and Zip Code _____
Ciudad, Estado y Codigo Postal de la Madre

Area Code and phone number_____
Area Telefonica y numero de telefono

Mother's Social Security number _____
Numero de Seguro Social de la Madre

Annual income or public assistance _____
Ingresos Anuales o Asistencia Publica

Mother's State of residence _____ Mother's Country of citizenship_____
Estado de Residencia de la Madre Pais de Origen de la Madre

FINANCIAL STATEMENT
Reporte Financiero

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

Todas las areas de este formulario deben ser completados o seran regresados al solicitante sin accion.

1) How many people live in the household with the patient? _____
Cuantas personas viven en la casa con el paciente?

2) What is the net monthly income (take-home pay, after taxes) from all sources in the household, including public assistance? _____
Cual es el ingreso neto (despues de impuestos) de todos los recursos del hogar, incluyendo asistencia publica?

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 totals del hogar (incluyendo renta, electricidad, gas, agua, lavanderia, comida, gasoline y prestamos o pagos extras)?

If greater than the amount on Line 2, please explain _____
Si el gasto total es mas que el de la linea 2, por favor explique.

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

Cual es el total de deuda del hogar (prestamos, tarjetas de credito, deberes)?

5) What is the total value of all property (including house, land and automobiles)? _____
Cual es el valor total de todas las propiedads? (Incluyendo hogar, automobiles, propiedades)?

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

Hay algunos recursos de dinero para que usen como asistencia hacia el pago del audifono, seguro, Medicaid…

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

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

Hay alguien en el hogar que recibe asistencia publica? Si_____No_____

Estampillas de Comida? Si_____No_____

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

Por Favor especifique tipy de asistencia de las necesidades de pacientes (Implante Coclear, Audifonos, Tratamiento Medico)

_____

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.

Certifico que la informacion esta correcta de lo mejor de mi conocimiento y estoy de acuerdo en proveer comprobante de pago cuando sea requerido. Comprendo que el costo determinado para este paciente es sujeto a cambiar conforme cambie el ingreso familiar.Tambien comprendo que falta de proveer comprobante de page me hara ineligible para el costo adaptado y la cobranza del balance para este paciente automaticamente sera un cobro por parte del DALLAS HEARING FOUNDATION. No tengo seguro para cubrir lost costos. Si soy aprobado para la asistencia, comprendo que debo proveer informacion financier anualmente.

_____ _____ _____

Signature of Parent or Guardian Date Signed Fecha

Firma de Padre/ Madre o Guardian de Familia

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:

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.

Consentimiento de Padre: si el aplicante es menor de edad; Soy padre/madre o guardian legal del participante y estoy de acuerdo en que el formulario de Excuplacion de Obligaciones es un documento legal para mi y mi hijo(a) menor.

Signature of Parent/Guardian_____ Date _____
Firma del Padre/Madre 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 Publico del Estado de: