



Dr. Ann Stadelmaier Hearing Aid Fund
Financial Assistance Application

www.hearingevaluationservices.com

Applicant's Name _____ Date _____

Street _____ City _____ State ____ Zip _____ Phone _____

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

Employer _____ Job Title _____

Name of Person Needing Assistance _____ Age ____ Relationship to Applicant _____

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

Emergency Contact Name _____ Relationship _____ Phone _____

Name of Audiologist/Physician _____ City _____ Phone _____

Do you currently have a Hearing Aid(s)? **Y** **N** Which Ear(s)? **L** **R** How Old? _____ 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 \$ _____ Medicare Part D \$ _____	
Supplemental Security Income (SSI)	<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	
Veteran's Benefits	<input type="checkbox"/> YES <input type="checkbox"/> NO	MONTHLY AMOUNT \$ _____		
Disability private or NYS	<input type="checkbox"/> YES <input type="checkbox"/> NO	WEEKLY AMOUNT \$ _____	Source	
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	

TYPE OF INCOME	CHECK ONE (✓)	IF YES, GIVE AMOUNT		Who Receives?
Alimony including payments for mortgage, utility bills, etc.	<input type="checkbox"/> YES <input type="checkbox"/> NO	MONTHLY AMOUNT \$ _____	Source	
Rental Income (apartment, garage, land, etc.)	<input type="checkbox"/> YES <input type="checkbox"/> NO	MONTHLY AMOUNT \$ _____	Type of Rental	
Room/Board (received) etc.	<input type="checkbox"/> YES <input type="checkbox"/> NO	MONTHLY AMOUNT \$ _____	Name of Roomer/ Boarder?	
Worker's Compensation	<input type="checkbox"/> YES <input type="checkbox"/> NO	WEEKLY AMOUNT \$ _____		
Unemployment Benefits	<input type="checkbox"/> YES <input type="checkbox"/> NO	WEEKLY AMOUNT \$ _____		
Total value of all savings, checking, CD's, money market accounts, etc.		Savings \$ _____ Checking \$ _____ CD's \$ _____ Money Market \$ _____ Other \$ _____	Source(s)	
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 \$ _____ _____ WEEKLY AMOUNT before deductions \$ _____	Employer _____ Employer	
Is there any other income from any other source?	<input type="checkbox"/> YES <input type="checkbox"/> NO	Yearly AMOUNT \$ _____	Source(s)	

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 Signed

Hearing Evaluation Services of Buffalo, Inc.



Dr. Ann Stadelmaier Hearing Aid Fund

Applicant Information Sheet

www.HearingEvaluationServices.com

Dr. Ann 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 a final wish of hers 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 need. To apply for funding the applicant is to submit a financial assistance application along with a copy of their most recently filed IRS tax return and a copy of a recent audiogram. The Dr. Ann 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 Oticon digital hearing aid in either a full-shell, half-shell, canal or behind-the-ear style. An earmold 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 three-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:

- To submit a financial assistance application along with their most recently filed IRS tax return and a copy of a recent audiogram (within one year).
- If the applicant does not have a recent audiogram they should contact Hearing Evaluation Services to schedule an appointment (833-4488).
- Once the approval letter is received the patient is to contact Hearing Evaluation Services (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 patient may be responsible for a one time \$150 dispensing fee which covers all office visits within the first year.

Hearing Evaluation Services realizes that hearing is the basis for all human communication.

It is our wish is to assist those in need.

Please contact our office at 833-4488 if you have any questions, or would like to obtain a financial assistance application.