



Dear Applicant,

Thank you for contacting HELPING PEOPLE HEAR AGAIN, the nonprofit organization dedicated to providing no cost hearing aid assistance. Our goal is to make available hearing aids (includes consultation, screening and one annual check up) at no cost to those who qualify and reside in the Coachella Valley. With the help of our associate audiologists, HELPING PEOPLE HEAR AGAIN is designed to assist those with no other financial resources available in acquiring hearing devices.

Each application is reviewed on a case-by-case basis, so it is important we have all of the facts. If you have other options for assistance that include: family support, insurance, state Medicaid program, third party financing, vocational rehabilitation, school district, VA, church groups, state, local programs, or some combination of these, they will all affect your eligibility.

If an applicant has family support or **funds** available in money market accounts, mutual funds, 401(k) plans, IRAs, certificates of deposits (CDs), checking/saving accounts, stocks, bonds or T-bills, **this may not be the program for you.** HELPING PEOPLE HEAR AGAIN considers all these when determining eligibility. If applicants do not fall within the guidelines, or are otherwise deemed ineligible due to asset levels or related factors, assistance will be denied.

Please complete the following forms to the best of your ability and return to address stated throughout the documents. All applicants will be notified by mail regarding approval or denial.

If you need help or have a question please call HELPING PEOPLE HEAR AGAIN 760.776.1738.

HELPING PEOPLE HEAR AGAIN
40101 Monterey Ave, STE B1, PMB 327
Rancho Mirage, CA 92270



HOW TO COMPLETE THE PROCESS

Review the **Information to Consider Before Completing the HELPING PEOPLE HEAR AGAIN application** below.

1. Review the **Final Checklist** for steps and documentation needed. **Please send ALL application materials at the same time to:**
- 2.

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Applications are processed once a month. **Once you mail your application, please wait at least one month before you call for a status check.**

INFORMATION TO CONSIDER BEFORE COMPLETING THE HELPING PEOPLE HEAR AGAIN APPLICATIONS

1. Income Guidelines: **All income figures are GROSS. (these are only guidelines)**
- 2.

Size of Family unit	HPHA Income Guideline	Size of Family unit	HPHA Income Guideline
1	\$17,867 or less	5	\$42,227 or less
2	\$23,957 or less	6	\$48,317 or less
3	\$30,047 or less	7	\$54,407 or less
4	\$36,137 or less	8	\$60,497 or less

NOTE: *For family units with more than 8 members, add \$6,090 for each additional member.*

3. **Application**
4. **In determining eligibility, HELPING PEOPLE HEAR AGAIN considers the following:**
 - a. **Household Size:** (Household is defined as the number of people financially dependent on each other).
 - b. **Gross Monthly or Annual Income:** From all in the household who have income. **Possible sources of income are:** Social Security, SSI, child support, welfare, work pension, VA pension, public assistance, AFDC, wages, interest from stocks, IRAs, 401 (k)s, alimony, disability.
 - c. **Assets:** Checking, annuities, life insurance, CDs, burial accounts, money market accounts, savings, stocks/bonds, IRA/401(k).



FINAL CHECKLIST

All items create a complete application. Missing items will delay the process.

DO NOT SEND ORIGINAL DOCUMENTS; THEY WILL NOT BE RETURNED.

- Complete all necessary pages – signature required on several pages.
- Send copy of all IRS forms 1040 for previous year
- Provide proof of income from all sources (GROSS income for current year)
- Send copies of all pages of bank statements (all accounts) for the most recent three (3) months
- Complete medical clearance (page 8) release (signed by primary physician) or waiver (signed by the patient)
- Submit most recent statement for all CDs, Money Market Accounts, Burial Accounts, IRAs, 401Ks, Annuities, Stocks and/or Bonds you hold
- Send copy of subsidized housing approval notice (if applicable)
- Send Medicaid identification form (if you are a Medicaid recipient)

**Additional information may be needed after initial review of application is completed

HELPING PEOPLE HEAR AGAIN reserves the right to change criteria at any time without prior written notice.

Please mail completed form and required items to:

**HELPING PEOPLE HEAR AGAIN
40101 Monterey Ave, STE B1, PMB 327
Rancho Mirage, CA 92270**



Application For Hearing Aid Assistance

(Please Print Clearly)

Date: _____

Applicant's Name: First _____ Middle _____ Last _____

Date of Birth: _____ Age: _____ Male Female

Social Security Number: _____

Marital Status: Married Single Divorced Widowed Separated

Number in Household: _____
(Household is defined as all those financially dependent on each other)

Email: _____

Mailing Address:

Street: _____ Apt # _____

City: _____ County: _____ State: _____ Zip _____

Home Phone: _____

Work Phone: _____

If Minor, Parent/Guardian's Name(s): _____

Person, if other than applicant, completing form. If Minor, list Parent/Guardian's Information

Name: _____

Relationship to Applicant: _____

Phone: _____

INCOME

If applicant is a minor, list Parent/Guardian's income information



Application continued

List all sources of income (i.e., salary, social security, alimony, child support, pension, stocks, bonds, etc.)

SOURCE: _____

AMOUNT: _____

Applicant:

A. _____ \$ _____ Month or Year
(circle one)

B. _____ \$ _____ Month or Year
(circle one)

Spouse/Other:

C. _____ \$ _____ Month or Year
(circle one)

D. _____ \$ _____ Month or Year
(circle one)



ANSWER ALL QUESTIONS. Unanswered questions will delay the process.

Do you currently have:

	Yes	No	
Checking Account	<input type="checkbox"/>	<input type="checkbox"/>	If yes, provide all pages of 3 months of current bank statements
Savings Account	<input type="checkbox"/>	<input type="checkbox"/>	If yes, provide all pages of 3 months of current bank statements
Credit Card	<input type="checkbox"/>	<input type="checkbox"/>	If yes, provide the most recent statement
CD(s)	<input type="checkbox"/>	<input type="checkbox"/>	If yes, provide the most recent statement
Stocks/Bonds	<input type="checkbox"/>	<input type="checkbox"/>	If yes, provide the most recent statement
Annuity	<input type="checkbox"/>	<input type="checkbox"/>	If yes, provide the most recent statement
IRA/401K	<input type="checkbox"/>	<input type="checkbox"/>	If yes, provide the most recent statement
Money Market Acct	<input type="checkbox"/>	<input type="checkbox"/>	If yes, provide the most recent statement
Burial Account	<input type="checkbox"/>	<input type="checkbox"/>	If yes, provide the most recent statement
Do you live in subsidized housing	<input type="checkbox"/>	<input type="checkbox"/>	If yes, provide documentation of approval notice and rent amount

Are you a Medicaid recipient? Yes No

If yes, provide copy of Medicaid Identification Form

Do you currently own hearing aids? Yes No If yes, how many? _____

Do you currently owe child support? Yes No If yes, how much? _____

Do you have any prior felonies? Yes No If yes, please provide detail

Do you own your own home? Yes No

Employment Status: Employed Other Retired Disabled

Name of Current Employer: _____

Phone: _____

How long have you been employed there? _____ (Years/Months)

Work Description: _____



RELEASE OF INFORMATION

I understand the information I submit to the HELPING PEOPLE HEAR AGAIN concerning my annual income, family size, family resources, insurance, medical history and all financial information are subject to verification by the HELPING PEOPLE HEAR AGAIN and/or their agents. This verification will be done by phone, letter, email or credit check.

I understand that if I knowingly omit or submit false information, I will be denied consideration for assistance at any point during the process.

Applicant Name: _____

Spouse's Name _____

Date of Birth: _____

Date of Birth: _____

Applicant Signature: _____

Spouse's Signature: _____

(If Minor, Parent/Guardian signature required)

If signed by Power of Attorney (POA), please send copy of POA. The laws of the state of California shall govern the resulting transaction and any claim or dispute arising out of such transaction.

PHYSICIAN STATEMENT

To be signed by patient's Primary Physician

Date: _____

Name (please print): _____

I have examined this patient and have determined that there is no medical reason why this individual should not be considered a candidate for hearing aid use.

Physician Name (please print): _____

Physician Signature: _____

I, _____, declare on this day _____

that I do not have a primary physician and am willing to proceed without the above physicians statement.

Signature of patient: _____



CONSENT FOR MEDICAL EVALUATION FOR HEARING AID USE

Date: _____

Patient Name (please print): _____

I understand and fully agree that as a participant in this program the medical evaluation, consultation, examinations, fittings, and follow-up appointment must be conducted by the physician designated by the Board of Directors of HELPING PEOPLE HEAR AGAIN.

Patient Signature: _____



Agreement of Helping People Hear Again Terms and Conditions

I understand that non profit organization HELPING PEOPLE HEAR AGAIN is under no obligation to furnish me with a new or refurbished hearing device. I fully understand that the Board of Directors has the ultimate right and authority to approve or decline my application at their sole discretion. The decision of the Board of Directors is final. HELPING PEOPLE HEAR AGAIN declares and affirms a policy of equal opportunity and nondiscrimination in providing services to the public. We do not discriminate on the basis of race, color, national and ethnic origin, age, religion or sexual orientation in the administration of our acceptance policies or programs. I consent to these terms, and further agree to hold HELPING PEOPLE HEAR AGAIN, its employees, associates, affiliates, Directors and anyone else associated with the non profit organization, harmless from any and all claims resulting from my participation in this program

Applicant Name: _____

Applicant Signature: _____

Date: _____

(If Minor, Parent/Guardian signature required)

Approved by:

Helping People Hear Again Board Member Name (please print)_____

Helping People Hear Again Board Member Signature:_____

Date: _____