

Funding Toolkit

**for Parents of Children
who are Deaf or Hard of Hearing**



This is a resource for parents about different funding opportunities in Nebraska for assistance covering the costs associated with hearing aids, cochlear implants and other needs of children who are deaf or hard of hearing. The creators do not provide funding for families. It is at the discretion of the organizations and companies listed for each source of funding. Eligibility criteria and availability of funds may change without notice. Please contact the organization to verify details before applying.

Revised February 2012

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This information was compiled by Laura Barrett, Central/Western Nebraska Partnership for Children who are Deaf or Hard of Hearing. Information is accurate as of February 2012.

To update or add funding sources to this document, please contact:

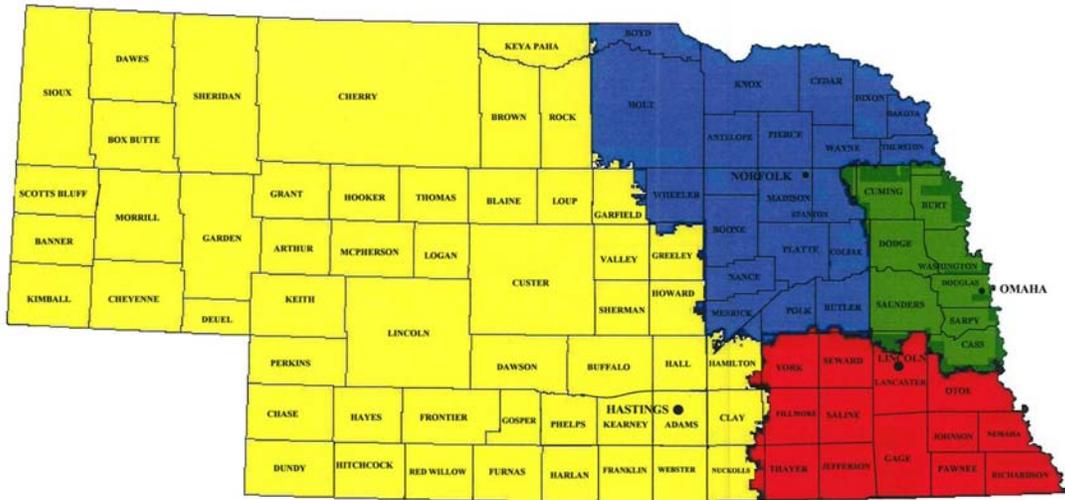
Laura Barrett
4215 Ave I
Scottsbluff, NE 69361
lbarrett@esu13.org
(308) 635-3696

Funding Overview

Title	Hearing Loss Qualification	Income Restrictions	Assistance Available	Page #
Audient	Any loss	250% of the Federal Poverty	Cost assistance with hearing aids	5
BAHA Assistance Program	BAHA Implant Candidate	None listed	BAHA Implant funding assistance	9
Charles Foster Crippled Children's Memorial Fund	Any loss	200% of the Federal Poverty	Maximum gift per recipient is \$1,000	18
Civic and Service Organizations	Any loss	Varies	Varies	20
Cochlear Implant Assistance Program	Cochlear Implant Candidate	None listed	Cochlear Implant Funding	21
Disabled Children's Relief Fund	Any loss	Yes	Hearing aid funding assistance	31
Easter Seals	Any loss	None listed	Hearing aids, augmentative communication systems, etc	32
First Hand Foundation	Any loss	No additional insurance	Clinical visits, hearing aids, travel expenses	33
HEAR NOW	Any loss	Yes	Hearing aids	38
HIKE Fund	Any loss	Yes	Hearing aids and assistive listening devices	49
Kids Connection	Any loss	Yes	Hearing tests	57
Medicaid	Any loss	Yes	Hearing devices	60
Medically Handicapped Children's Fund	Severe loss or greater	None listed	Hearing tests, assistive technology	61
Miracle Ear Children's Foundation	Any loss	Yes	Hearing aid fittings	62
Nebraska Children's Hearing Aid Loaner Bank and Hear U Nebraska Fund	Any loss	None listed	Hearing aid loaners and ear molds	67
Nebraska Specialized Telecommunications Equipment Program	Any loss	None listed	Telecommunication Equipment	72
Project Endeavor	Bilateral 40 dB	No	Broadband Internet and technology	77
Small Steps in Speech	Any Loss	Yes	Communication assistance (therapy, devices, training)	79
Sorenson Video Relay	Sign Language User	No	Video Relay Equipment	85
TPA Scholarship	Any loss	None listed	Various supports	86
UnitedHealthcare	Any loss	Yes	Various supports	92

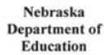
Nebraska

Regional Programs for Students Who are Deaf or Hard of Hearing



Regional Programs for Students who are Deaf or Hard of Hearing

	Central/Western Partnership	402-463-5611	sczaplew@esu9.org	Sue Czaplewski, Coordinator
	Metro Regional Program	402-339-2090	diane_meyer@ralstonschools.org	Diane L. Meyer, Coordinator
	Northeast Nebraska Regional Program	402-644-2507	jhoffart@npsne.org	Jill Hoffart, Coordinator
	Southeast Nebraska Regional Program	402-436-1897	jbird@lps.org	Jill Bird, Coordinator



Information Source:
Regional Programs - Nebraska Department of Education
Rhonda Fleischer, State Liaison for Programs for Children Who are Deaf or Hard of Hearing, (402) 463-5611, rfleisch@esu9.org

Central/Western Partnership

Sue Czaplewski

Coordinator

Educational Service Unit #9

P.O. Box 2047

Hastings NE 68902-2047

402-463-5611 TTY/Voice

FAX: 402-463-9555

sczaplew@esu9.org

Northeast Nebraska Regional Program

Jill Hoffart

Program Coordinator

Norfolk Public Schools

512 Philip Ave Box 139

Norfolk, NE 68702

(402) 644-2507

jhoffart@npsne.org

Metro Regional Program

Diane Meyer

Administrative Coordinator

Karen Western Elementary

6224 H St

Omaha NE 68117

(402) 339-2090

(402) 731-0952

Diane_Meyer@ralstonschools.org

Southeast Nebraska Regional Program

Jill Bird

Program Coordinator

Rousseau Elementary

3701 S. 33rd Street

Lincoln, NE 68506

(402) 436-1896 V/TTY

Fax: (402) 436-1897

jbird@lps.org

Audient

AUDIENT helps low income people nationwide access quality hearing aids and related care at a significantly lower cost. AUDIENT income qualifies families to be eligible for a discount on brand name hearing aids available through the AUDIENT Alliance's national network of dedicated hearing care providers. Brand selection includes Oticon, Phonak, Siemens, Widex, & Unitron hearing aids.

How Does AUDIENT Help?

AUDIENT lowers the cost of quality hearing aids and related care for income qualified participants.

The payment an AUDIENT participant will need to pay depends on the hearing aids recommended by the AUDIENT hearing care provider.

The range of cost AUDIENT will collect from the income qualified participant are:

- * \$700 to \$975 for one hearing aid or
- * \$1,150 - \$1,575 for two hearing aids.*

These costs include hearing aid(s), a fitting, three adjustments and a limited warranty.

*Costs are subject to change without notice.

Who is eligible?

AUDIENT is a nationwide program available to households earning up to 250% above the national poverty level. There is no age qualification for AUDIENT, and we are happy to help children as well as seniors. Look at the chart below to see if you fall within the income guidelines. When assessing household income, AUDIENT considers wages/salaries and pensions/annuities as well as Social Security income.

Contact:

EPIC Hearing Services
17870 Castleton St., Suite 320
City of Industry, CA 91748
Toll Free: 866-956-5400
hear@epichearing.com
<http://www.audientalliance.org>



Administered by EPIC Hearing Healthcare 3191 W. Temple Ave. Suite 200 Pomona, CA 91768
 Toll Free: 866-956-5400 Fax: 626-435-0188

Dear AUDIENT Candidate,

Thank you for your interest in AUDIENT, an alliance for accessible hearing care, an affiliate of the Northwest Lions Foundation for Sight & Hearing. Attached you will find the two page AUDIENT application. Please mail or fax the completed and signed form to EPIC Hearing Healthcare for candidacy consideration

Once you have been income qualified **you will pay in the range of \$700 to \$975 for one hearing aid and related care, or \$1150 to \$1575 for two hearing aids and related care when ordered at the same time***. This includes: a fitting, three adjustments during the first year, and fully digital hearing aid(s). This does not include the hearing evaluation. The cost is based on the type of hearing aid(s) that suit your hearing needs. Your AUDIENT Hearing Care Provider will work with you to help you understand which of the hearing aids available through AUDIENT will best suit your hearing needs.

You can qualify if you are earning less than these annual incomes:

AUDIENT Income Qualification Chart			
Size of Family Unit	48 Contiguous States and D.C.	Alaska	Hawaii
1	\$27,075	\$33,825	\$31,150
2	\$36,425	\$45,525	\$41,900
3	\$45,775	\$57,225	\$52,650
For each additional person, add:	\$9,350	\$11,700	\$10,750

Please complete the enclosed form and fax it to EPIC at 626-435-0188, or mail to:

EPIC Hearing Healthcare
 3191 W. Temple Ave Suite 200
 Pomona, CA 91768

Once you are approved, we will contact you to coordinate your referral to an AUDIENT Program participating hearing care professional. If you have any questions please call us at 1-866-956-5400.

With best wishes,

Dru Coleman
 Dru Coleman
 Program Services Administrator

This program is made possible through the dedication of the AUDIENT providers and suppliers to serve AUDIENT income qualified patients.



An Alliance for Accessible Hearing Care

Northwest Lions Foundation for Sight & Hearing

Administered by EPIC Hearing Healthcare 3191 W. Temple Ave. Suite 200 Pomona, CA 91768

Toll Free: 866-956-5400 Fax: 626-435-0188

AUDIENT Program Application Form

Please complete this *two page* form and send it to:

EPIC Hearing Healthcare
3191 W. Temple Ave Suite 200
Pomona, CA 91768
Or fax to: **626-435-0188**

Patient Information:

Full Name: (Please print) _____

Address: _____

City: _____ State: _____ Zip code: _____

Phone Number: (_____) _____ Fax: (_____) _____

E-mail: _____

Male ___ Female ___

Date of Birth _____

Care Giver/Counselor Information: (Fill in if candidate has difficulties communicating by phone or if referred by counselor.)

Full Name: (Please print) _____

Relation to Candidate: _____

Address: _____

City: _____ State: _____ Zip code: _____

Phone Number: (_____) _____ Fax: (_____) _____

E-mail: _____

Hearing Care Provider Information *Optional*

If you found out about the AUDIENT program from your Hearing Care Provider, please provide their information here:

Name of Clinic: (Please print) _____

Name of Hearing Care Provider: _____

Address: _____

City: _____ State: _____ Zip code: _____

Phone Number: (_____) _____ Fax: (_____) _____

Additional Information (Please circle either Yes or No)

Do you currently own or wear hearing aids?	Yes	No
Have you had a hearing test/audiogram recently?	Yes	No

Where did you learn about AUDIENT? _____

Preferred Form of Payment

If you qualify for the AUDIENT Program and upon assessment of your hearing and the recommendation of hearing aids by your provider, which form of payment would you prefer? (Please mark one.)

Certified Check Credit Card

Gross Annual Income for Candidate's Family \$ _____

Number of family members dependent on income: (including yourself) _____

Certification of Total Income

I certify and declare under penalty of perjury that the figure listed above is reflective of my **total annual gross income**.

If I qualify **I will be responsible for paying the total costs associated with my hearing care.** Depending on the hearing aid recommended by my AUDIENT hearing care provider the cost for one hearing aid and related care is in the range of \$700 to \$975, the cost for two hearing aids and related care when ordered at the same time is in the range of \$1,150 to \$1,575. * This cost covers the AUDIENT hearing care provider fitting fee, three adjustments during the first year, fully digital hearing aid(s), and a one year limited manufacturer's warranty. There is no warranty on ear molds. The cost is based on the hearing aid(s) suitable to my hearing needs as recommended by my AUDIENT hearing care provider. Office visits in excess may incur a charge collected directly by the provider. The one year limited hearing aid manufacturer's warranty covers repairs, and one time loss or damage. The payment of a \$200 processing fee for each replacement hearing aid will be my responsibility*. I agree to be responsible for any provider related expenses pertaining to dispensing the replacement hearing aid(s). Those expenses will be billed directly to me by the provider. I understand that the fees are subject to change without advanced notice.

Hearing aids returned because they did not benefit my hearing loss can be refunded if returned to my AUDIENT Hearing Care Provider in good condition before the end of the 30-day trial period. PLEASE NOTE: In the case of purchasing two hearing aids at the same time, and returning only one of the them to the AUDIENT Hearing Care Provider in good condition before the end of the 30-day trial period, the amount that will be refunded to me or the party that paid for the hearing aid(s), will be the difference between the cost of purchasing one hearing aid at a time rather than half the cost of two hearing aids purchased at the same time.

I understand that EPIC Hearing Healthcare is a third party administrator for the AUDIENT provider partners.

Name: (Please print) _____

Signed: _____

Date: _____

When you have completed all of the above, please send it to:

**EPIC Hearing Healthcare
3191 W. Temple Ave Suite 200
Pomona, CA 91768
Or Fax to: (626) 435-0188**

If you have any questions, please contact EPIC toll free. **1-866-956-5400**

BAHA Assistance Program

In early 2006, the CNI Center for Hearing took on the task of helping the financially-challenged patients and their families obtain this life-enriching device by establishing the BAHA Assistance Program. Through a cooperative effort of CNI Center for Hearing, Cochlear Americas and a team of dedicated medical professionals, this program may be able to assist qualified candidates needing the BAHA device. The BAHA Assistance Program awards only the actual system itself (the internal and external components) - patients are still responsible for other costs associated with the procedure such as the physician, hospital, surgical, and audiological fees. The average out-of-pocket cost for candidates who receive a BAHA device through the CNI Center for Hearing is approximately \$10,000-\$15,000.

The supply of BAHA devices for this program is limited. The CNI Center for Hearing will submit a request to the manufacturer for a device only if a completed application is approved by the BAHA Assistance Program. Availability of the BAHA device will then be determined at the discretion of the manufacturer.

Eligibility Determination

1. Applications will be considered only if the candidate is a permanent, legal resident of the United States. In the case of an applicant who is under 18 years of age at the time of the application, the applicant's legal guardian(s) must show proof of permanent, legal US residence as well.
2. Applicants must be evaluated and determined to be a candidate for a Baha device prior to applying to this Assistance Program.
3. Baha candidates, who either have no health insurance or whose health insurance excludes ALL aspects of the Baha process and device, are eligible to apply.
4. Applicants must seek assistance from this program prior to obtaining their Baha. Applications for reimbursement following the procedure will not be considered.
5. Applicants must provide all required attachments and documentation with their completed applications before being considered for this Assistance Program. Applicants will be contacted if incomplete applications are received and will be given a maximum of 6 months in which to submit all required documents. Failure to provide all materials within 6 months will result in the application being classified as inactive and discarded. If an applicant later wishes to be reinstated for consideration, all paperwork must be re-submitted under the guidelines in place at that time.
6. Applications may be considered from applicants who already have a Baha if the applicant is attempting to replace a failed internal device no longer under warranty or service contract.
7. Applications will not be accepted from recipients who are seeking assistance with replacing their Baha system's external equipment. Applicants with this need are encouraged to check with their insurance carriers for potential coverage or with their manufacturer.
8. Applications for a bilateral BAHA device will not be accepted.

BAHA Assistance Program
Colorado Neurological Institute
701 East Hampden Ave., Suite 330
Englewood, CO 80113

<http://www.thecni.org/utility/showArticle/?objectID=975>

Information that you provide will be kept strictly confidential. If your application is selected for funding, the resulting transaction, and any claim or dispute arising out of such transaction, shall be governed by the laws of the State of Colorado.

APPLICANT/FAMILY INFORMATION

Date: _____

Name of Applicant (patient for whom the Baha is being requested):

Gender M _____ F _____ Date of Birth: _____

Address (Street/City/State/Zip/Phone):

Daytime Phone: _____

Email address of applicant/parents: _____

Applicant's Social Security Number: _____

Mother's Name: (if applicant is a minor) _____

Address/Phone: _____

Father's Name: (if applicant is a minor) _____

Address/Phone: _____

Names and Ages of Dependents (or Siblings if applicant is a minor):

Relationship & Name of Person Completing Application: _____

REASON FOR ASSISTANCE

Please state why assistance is needed: _____

What other sources of assistance have you sought or have been offered (foundations, fund-raisers, employee assistance funds, etc) and what is the result? _____

CANDIDACY

Has the applicant been approved as a candidate by a qualified Baha center? Yes _____ No _____ (candidates must be evaluated prior to being considered for the Baha Assistance Program)

Baha Surgeon/Neurotologist _____

Baha Team Coordinator – Name _____ Phone _____ Email _____

Center Name/City/State _____

EDUCATIONAL HISTORY (if applicant is a minor)

School Attending _____ Primary Teacher _____

Address (City/State/Phone): _____

Additional Therapy or Rehabilitation Programs _____

HEALTH INSURANCE

Is the applicant covered under any Health Insurance plan (private or government)? Yes ___ No ___

Policy Holder: _____ Identification No. _____ Group No. _____

Name of Insurance _____ Phone _____

Address _____

Has coverage been denied for ALL aspects of the Baha procedure and equipment? Yes ___ No ___

If health insurance has denied coverage, has an appeal been filed? Yes ___ No ___

If an appeal has been filed, what is the result of that filing? _____ (please attach all correspondence)

Does the applicant have Medicaid or Medicare Coverage (Part B)? Yes ___ No ___

If no, has an application for Medicaid or Medicare Coverage Part B been submitted? Yes ___ No ___

If yes, what was the result? _____ (Please attach all correspondence to/from Medicaid/Medicare)

INCOME

Name of Employer (of adult applicant and/or spouse/partner – provide information for **ALL** household members):

Address: _____

Phone: _____ Years/Months of employment with employer*: _____

Spouse's/Partner's Employer & Annual Salary/Wages _____

Father's Employer & Annual Salary/Wages (if applicant is a minor): _____

Employer's Address & Phone: _____

Years/months of employment with employer*: _____

Mother's Employer & Annual Salary/Wages (if applicant is a minor): _____

Employer's Address & Phone: _____

Years/months of employment with employer*: _____

*If employment is less than 2 years, please attach information for each employer of the past 3 years)

If applicant or either parent is not currently employed, please provide explanation:

Is the applicant receiving SSI/SSD (Supplemental Security Income/Social Security Disability)? Yes___ No___

If yes, when did benefits begin? (indicate the date)

If no, has an application been submitted? Yes___ No___ What were the results? _____

(Please attach any correspondence to/from Social Security Administration office)

Combined Yearly Household Income of Applicant and/or Spouse/Partner or Both Parents (if applicant is a minor): _____

Identify all income sources and amounts (i.e., salary, social security, military, alimony, child support, real estate, rental income, dividends from stocks/bonds, etc. – use additional paper, if needed)

- a. _____ Monthly amount: _____
- b. _____ Monthly amount: _____
- c. _____ Monthly amount: _____

Checking Account Balance: \$ _____ Name of Bank _____

Savings Account Balance: \$ _____ Name of Bank _____

Year and Make of Automobile(s) _____ Loan Balance _____

Year and Make of Automobile(s) _____ Loan Balance _____

Stocks/Bonds (do not include 401(k) or tax-deferred IRA retirement investments) _____

House/Property Value _____ Loan Balance _____ Equity Amount _____

Other assets (please list with current market and/or mortgage value – use separate sheet, if needed)

EXPENSES (monthly)

Rent/Mortgage _____ Water/Sewer _____ Food _____

Gas/Electric _____ Telephone _____ Clothing _____

Auto Payments _____ Pharmacy _____ Gasoline _____

Auto Insurance _____ Life Insurance _____ Health Insurance _____

Medical Expenses _____ Dental _____ Other (specify) _____

Creditor / Monthly Payment / Current Balance

Other expenses: _____

PERSONAL STATEMENT

To be written by applicant. If applicant is 13-18 years old, both the applicant and a parent should write separate statements. If applicant is less than 13 years of age, a statement from a parent is sufficient.

Please state how you think the Baha will improve/enhance the life of the applicant socially, educationally, professionally, etc. You may use extra paper, if needed.

What are the expectations for the change in the applicant's hearing ability?

Relationship to applicant & name of person who wrote Personal Statement _____

RELEASE & VERIFICATION OF INFORMATION / UNDERSTANDING OF TERMS

I understand that the information submitted to CNI concerning annual income, family size, family assets, insurance, and medical history are subject to verification by CNI or their agents. I also understand that if the information I submit is found to be false, such a determination will result in elimination from consideration for assistance. I further understand that the supply of Baha devices for this program is limited and that the CNI Center for Hearing's Baha Assistance Program will submit a request to the manufacturer for a device only if this application is approved following the review process. Availability of the Baha device will then be determined at the discretion of the manufacturer.

I further understand that, if this application is approved via the Baha Assistance Program, CNI will provide only the Baha device itself and will not be responsible for any other fees associated with the medical procedure. I understand that I will be solely responsible for the payment of expenses which may include but may not be limited to, the surgeon's, audiologist's, anesthesiologist's, and hospital's fees. I further understand that there will be ongoing expenses associated with the maintenance and performance of the Baha and by signing below I am indicating my commitment to accept and manage those expenses.

Applicant's Printed Name: _____

Signature (of Applicant or Parent): _____

Social Security Number: _____ Date: _____

Spouse's/Partner's Printed Name: _____

Signature of Spouse/Partner: _____

Social Security Number: _____ Date: _____

Father's Printed Name (if applicant is a minor): _____

Signature: _____

Social Security Number: _____ Date: _____

Mother's Printed Name (if applicant is a minor): _____

Signature: _____

Social Security Number: _____ Date: _____

MEDIA RELEASE (This section is optional and will not impact consideration for assistance.)

If requested, I agree to allow CNI to utilize video footage, photographs and/or our personal story regarding the Baha process in publications or for media release at the discretion of CNI.

Printed Name: _____

Signature: _____

Date: _____

AUTHORIZATION TO RELEASE/REQUEST RECORDS/INFORMATION
(to be completed and signed by patient or parent/guardian)

I authorize the Colorado Neurological Institute (501 c 3) Center for Hearing's Baha Assistance Program to release/request records/information to/from the following as it pertains to my request to obtain a Baha device. My signature releases CNI to view and process all confidential medical information.

Audiology/Surgical Team Coordinator: _____
Facility Name: _____
Phone: _____
Fax: _____
Email: _____

Neurotologist/Surgeon/Practice: _____
Phone: _____
Fax: _____

Hospital/Surgical Center & Name of Contact Person: _____
Phone: _____
Fax: _____
Email: _____

Primary Care or ENT Specialist: _____
Phone: _____
Fax: _____

Hearing Aid Audiologist/Facility: _____
Phone: _____
Fax: _____
Email: _____

Other (Parent, Spouse, Friend, Other – Please Specify): _____
Phone: _____
Fax: _____
Email: _____

Patient Name

Person authorized to sign for patient

Signature

Signature

Printed Name

Printed Name

Date of Birth

Relationship to Patient

Date

Date

Colorado Neurological Institute (CNI)
Center for Hearing

Baha Assistance Program

Statement of Agreement

(to be completed by Neurotologist/Baha Surgeon)

In accordance with the mission of the CNI Baha Assistance Program, I agree that the no-charge Baha system (internal and external components) for which _____ (**patient's name**) is being considered as a donation recipient, will be used exclusively for him/her and for no other patient; furthermore, the system will not be retained, nor sold nor given to any individual or organization, for any other purpose.

I agree that the aforementioned patient will not receive any invoice nor will payment of any kind be required of the patient, or patient's family in the case of a minor, or any insurance carrier, for the Baha system itself. I understand that this agreement pertains only to the equipment/hardware itself and does not necessarily reflect any financial arrangement regarding other fees including, but not limited to, surgeon's, audiologist's, anesthesiologist's, hospital's or laboratory's fees associated with the Baha procedure. In accordance with the spirit of the CNI Baha Assistance Program's mission, I agree that attempts will be made to have associated fees waived or reduced to a level approximating Medicare reimbursement.

If the CNI Baha Assistance Program agrees to award a no-charge Baha system to the aforementioned patient, I agree that I or my designee will provide the scheduled surgery or fitting date information to the CNI Baha Assistance Program not less than 14 days before the scheduled date and further agree that I or my designee will contact the program within 72 hours following the scheduled date of surgery/fitting to confirm the status of the procedure. If the surgery/fitting does not take place as scheduled, I agree that I or my designee will contact the CNI Baha Assistance Program with that information, as stated above, and will then provide updates at intervals not to exceed 7 days regarding the delay and/or re-scheduling.

I agree to comply with the CNI Baha Assistance Program and the device manufacturer's instructions in returning the donated system in its entirety, if the surgery/fitting of the aforementioned patient is cancelled or significantly delayed, at the discretion and request of the CNI Baha Assistance Program. I agree to comply with the manufacturer's instructions regarding the return of any back-up device.

I have reviewed the patient's current insurance coverage (if any) and have confirmed that no portion of the Baha surgery/fitting procedure, nor the equipment itself, is covered under his/her plan.

I agree that any claim or dispute arising out of the CNI Center for Hearing's Baha Assistance Program shall be governed by the laws of the State of Colorado.

Signature of Baha center representative

Printed name of Baha center representative

Date

Telephone

Email

Name of Candidate: _____

REQUIRED ATTACHMENTS (please send these with the completed application)

Document Type:	Must Include:
A. Proof of Permanent, Legal US Residence (photocopy permitted)	1. Birth Certificate OR United States Passport OR Certificate of Naturalization (Form N550) OR a Green Card (Resident Alien Card). Note – If applicant is a minor, parent(s)/guardian(s) must submit proof for self(selves) as well as for the child
B. Income/Benefits (photocopy permitted)	1. Signed, dated, complete copy of previous year's tax return 2. Past 3 months' paycheck stubs or statement of social security/welfare payments of applicant and/or spouse/partner, or parent(s) if applicant is a minor
C. Insurance Documents (photocopies permitted)	1. Copy of front/back of insurance card of applicant 2. Complete insurance benefit booklet 3. Copies of all appeal and denial correspondence to/from insurance company – two documented denials/appeals are required
D. Auth. to Release / Request Information (original required)	1. Completed, signed Authorization to Release/Request Information (page 6 of application – please complete entire form)
E. Listing of Applicant's Out-of-Pocket Expenses (excluding the Baha system) (original required)	1. Complete listing from Baha center on letterhead of <u>all expenses associated with procedure for which the applicant will be responsible</u> , including but not limited to: the surgeon's, audiologist's, anesthesiologist's and hospital/surgical center's fees
F. Baha Audiologist's Summary (testing and all statements/reports must be within the last 12 months) (photocopy permitted of items 1-4; original of item 5 on letterhead required)	1. Unaided Audiogram a. Air Conduction and Bone Conduction c. SRT d. Word Recognition 2. Aided Audiogram (age appropriate) 3. Etiology, type, onset & duration of deafness 4. Hearing Aid History – when aided, model/type of aids, working status, consistency of use, and benefit of aids 5. Overall impression of candidate as a Baha user (include summary of patient's/family's expectations of results, any counseling regarding those expectations, motivation/commitment to rehab, etc)
G. Neurotologist's / Surgeon's Medical Summary (date of testing and assessment must be within the last 12 months) (photocopy permitted of items 1-2; original of item 3 on letterhead required)	1. Ear health/history 2. General medical history 3. Overall impression of applicant as a Baha user. Please include a summary of physician's expectations of results for the applicant, a statement of summary of treatment options for the applicant and a statement regarding the applicant's/family's insurance coverage, if any.
H. Surgeon's Statement of Agreement (original req'd)	1. Completed, signed Statement of Agreement (page 7 of application). The original document must be submitted – please do not submit a photocopy.

**Please return completed form to:
CNI Baha Assistance Program
701 E. Hampden Ave. #415
Englewood, CO 80113**

Please keep a copy of all submitted documents for your own records.

Incomplete applications will not be considered. Applicants will be contacted if incomplete applications are received and will be given a maximum of 6 months during which all required documents must be submitted and received. Failure to provide all materials within 6 months will result in the application being classified as inactive and destroyed. If an applicant later wishes to be reinstated for consideration, all paperwork must be re-submitted under the guidelines in place at that time.

Effective date: March, 2011

THE CHARLES FOSTER CRIPPLED CHILDREN'S MEMORIAL FUND

This Fund was established in 1949 by Charles E. Foster to "buy braces and other appliances for crippled children under 14 years of age who shall live in the state of Nebraska." Mr. Foster was a polio victim and envisioned that the Fund would be used to assist children who had been stricken with that disease. Later, when polio was almost entirely eradicated, the Board refocused the Fund's use to assist disabled children with other types of "appliances" while keeping in mind Mr. Foster's original intent.

This is a relatively small foundation. Consequently, Board policy provides that the maximum gift per recipient is \$1,000. It is also a Board policy not to repeat a contribution to any individual recipient. Grants for the maximum \$1,000 award will only be considered for families earning 200% or less of the federal poverty threshold. Except in extraordinary circumstances, grants will not be considered for families earning more than 400% of the federal poverty threshold. A family earning between 200% and 400% of the federal poverty threshold may be eligible for a partial grant.

To apply to the Fund, it is necessary to send the following:

1. A letter from the family or from someone on behalf of the family, including the child's address and date of birth. (This is to confirm that the applicant is a Nebraska resident and under the age of 14.)
2. A brief description of the disability.
3. A description of the item that is to be purchased. If the item is not specifically designed for a disabled child, it is also necessary to submit a letter from a doctor or other individual recommending the purchase (e.g., computer equipment).
4. The cost of the item and the name, address, and phone number of the company providing the item.
5. A copy of the family's latest income tax return or, if that is not available, a list showing annual income and expenses for the preceding year.

Please feel free to send any additional information you wish the Board to consider. All information should be sent to the following address:

Charles Foster Memorial Fund
c/o First National Bank Trust
1620 Dodge Street, Stop Code 1028
Omaha, NE 68197-1028
FAX (402) 633-3051

THE CHARLES FOSTER CRIPPLED CHILDREN'S MEMORIAL FUND:
2008 HHS Poverty Guidelines:

Persons in Family or Household	48 Contiguous States and D.C.	Alaska	Hawaii
1	\$10,400	\$13,000	\$11,960
2	14,000	17,500	16,100
3	17,600	22,000	20,240
4	21,200	26,500	24,380
5	24,800	31,000	28,520
6	28,400	35,500	32,660
7	32,000	40,000	36,800
8	35,600	44,500	40,940
For each additional person, add	3,600	4,500	4,140

SOURCE: *Federal Register*, Vol. 73, No. 15, January 23, 2008, pp. 3971-3972

<http://aspe.hhs.gov/poverty/08poverty.shtml>

Civic and Service Organizations:

Many community service organizations receive charitable donations to purchase hearing aids and other devices for people who are deaf or hard of hearing who have a low income. Organizations often recondition hearing aids and donate them to these individuals. Many of these organizations listed below are in your telephone directory; as well, your Local Chamber of Commerce might contain a list of contacts. Examples of organizations that may assist in hearing aid funding are:

Business and Professional Women

National Contact
2012 Massachusetts Ave NW Bellevue
Washington, DC 20036
<http://www.bpwusa.org/>

Nebraska BPW
2514 Sheridan Rd
Lincoln, NE 68123-1966
<http://nebpw.com/>

Civitan International

P.O. Box 130744
Birmingham, Alabama 35213-0744
<http://www.civitan.org>

Jaycees

PO Box 7
Tulsa, OK 74102-000
<http://www.usjaycees.org/>
<http://www.nejaycees.org/>

Quota International

We Share Foundation
1420 21st Street, N.W.
Washington, D.C. 20036
<http://www.quota.org/git/cq.htm>

Kiwanis Club

3636 Woodview Trace
Indianapolis, IN 46268-3196
<http://www.kiwanis.org/>

Rotary Club

One Rotary Center
1560 Sherman Ave.
Evanston, IL 60201, USA
<http://www.rotary.org>

Lions Club

300 W. 22nd Street
Oak Brook, IL 60523-8842
<http://www.lionsclubs.org/EN/index.shtml>

Sertoma International

1912 E. Meyer Blvd.
Kansas City, MO 64132
<http://www.sertoma.org>

Optimist Club

4494 Lindell Blvd.
St. Louis, MO 63108
<http://www.optimist.org/>

Soroptimist

1709 Spruce Street
Philadelphia, PA 19103-6103
<http://www.soroptimist.org>

Cochlear Implant Assistance Program

In the spring of 2003, the Center for Hearing took on the task of helping patients and families who are financially-challenged obtain this life-enriching device by establishing the Cochlear Implant Assistance Program (CIAP). Through a cooperative effort of device manufacturers and volunteer medical professionals, this new program is able to assist qualified candidates needing cochlear implants. To date, CIAP has fielded over 100 inquiries and awarded cochlear implants to several qualified candidates. While CIAP receives and awards no-charge implants, patients are still responsible for other costs associated with the procedure (physician, hospital, surgical, and audiological fees). CIAP will make every effort to request that implant teams reduce or waive their fees, however patients are ultimately responsible for any charges not waived. The average out-of-pocket cost for candidates who receive an implant through CIAP is approximately \$15,000.

CNI Cochlear Implant Assistance Program Eligibility Criteria

1. Applications will be considered only if the candidate is a permanent, legal resident of the United States. In the case of applicants who are under 18 years of age at the time of their application, the applicant's parents/legal guardians must show proof of permanent, legal US residence as well.
2. Applicants must be evaluated and determined to be a candidate for a cochlear implant (CI) prior to applying to this Assistance Program.
3. CI candidates without health insurance or whose health insurance excludes all aspects of the cochlear implant process, are eligible to apply.
4. Applicants must seek assistance from this program prior to obtaining their cochlear implant. Applications for reimbursement following the cochlear implant procedure will not be considered.
5. All applicants must provide all required attachments and documentation with their completed applications before being considered for this Assistance Program. Applicants will be contacted if documentation is missing and will be given a maximum of 6 months in which to submit all required materials. Failure to provide all documents within 6 months will result in the application being classified as inactive and discarded. If an applicant later wishes to be reinstated for consideration, all paperwork must be re-submitted under the guidelines in place at that time.
6. Applicants must demonstrate a commitment to appropriate therapy that promotes auditory skill development or their application for assistance will not be considered. A letter of support from the applicant's cochlear implant center verifying the applicant's level of commitment must accompany the application.
7. Applications may be considered from applicants who already have a CI if the applicant is attempting to replace a failed internal device no longer under warranty or service contract.
8. Applications will not be accepted from recipients who are seeking assistance with replacing their cochlear implant's external equipment. Applicants with this need are encouraged to check with their insurance carriers for potential coverage or with their manufacturer.
9. Applications for a bilateral implant will not be accepted.

Cochlear Implant Assistance Program
Colorado Neurological Institute
701 East Hampden Ave., Suite 330
Englewood, CO 80113
Phone: (303) 788-4010

<http://www.thecni.org/utility/showArticle/?objectID=368>

Information that you provide will be kept strictly confidential. If your application is selected for approval, the resulting transaction, and any claim or dispute arising out of such transaction, shall be governed by the laws of the State of Colorado.

APPLICANT/FAMILY INFORMATION

Date: _____

Name of Applicant (patient for whom the Cochlear Implant is being requested):

Gender M _____ F _____ Date of Birth: _____

Address (Street/City/State/Zip/Phone):

_____ Daytime Phone _____

Email address of applicant/parents: _____

Applicant's Social Security Number: _____

Mother's Name: (if applicant is a minor) _____

Address/Phone: _____

Father's Name: (if applicant is a minor) _____

Address/Phone: _____

Names and Ages of Dependents (or Siblings if applicant is a minor):

Relationship & Name of Person Completing Application: _____

DEVICE REQUESTED

Please specify preferred cochlear implant manufacturer and/or model: _____

Please state why assistance is needed: _____

What other sources of assistance have you sought or have been offered (foundations, fund-raisers, employee assistance funds, etc) and what is the result? _____

CANDIDACY

Has the applicant been approved as a candidate by a Cochlear Implant Center? Yes ___ No ___
(candidates must be evaluated prior to being considered for the Cochlear Implant Assistance Program)

Cochlear Implant Surgeon _____

CI Team Coordinator – Name _____ Phone _____ Email _____

Center Name/City/State _____

EDUCATIONAL HISTORY (if applicant is a minor)

School Attending _____ Primary Teacher _____

Address (City/State/Phone): _____

Type of Communication: Oral ___ Sign ___ Total Communication ___

Additional Therapy or Rehabilitation Programs _____

HEALTH INSURANCE

Is the applicant covered under any Health Insurance plan (private or government)? Yes ___ No ___

Policy Holder: _____ Identification No. _____ Group No. _____

Name of Insurance _____ Phone _____

Address _____

Has coverage been denied for the cochlear implant procedure? Yes ___ No ___

If health insurance has denied coverage, has an appeal been filed? Yes ___ No ___

If an appeal has been filed, what is the result of that filing? _____ (please attach all correspondence)

Does the applicant have Medicaid or Medicare Coverage (Part B)? Yes ___ No ___

If no, has an application for Medicaid or Medicare Coverage Part B been submitted? Yes ___ No ___

If yes, what was the result? _____ (Please attach all correspondence to/from Medicaid/Medicare)

INCOME

Name of Employer (of adult applicant and/or spouse/partner – provide information for **ALL** household members):

Address: _____

Phone: _____ Years/Months of employment with employer*: _____

Spouse's/Partner's Employer & Annual Salary/Wages _____

Father's Employer & Annual Salary/Wages (if applicant is a minor): _____

Employer's Address & Phone: _____

Years/months of employment with employer*: _____

Mother's Employer & Annual Salary Wages (if applicant is a minor): _____

Employer's Address & Phone: _____

Years/months of employment with employer*: _____

*If employment is less than 2 years, please attach information for each employer of the past 3 years)

If applicant or either parent is not currently employed, please provide explanation:

Is the applicant receiving SSI/SSD (Supplemental Security Income/Social Security Disability)? Yes ___ No ___

If yes, when did benefits begin? (provide the date) _____

If no, has an application been submitted? Yes ___ No ___ What were the results? _____

(Please attach any correspondence to/from Social Security Administration office)

Combined Yearly Household Income of Applicant and/or Spouse/Partner or Both Parents (if applicant is a minor): _____

Identify all income sources and amounts (i.e., salary, social security, military, alimony, child support, real estate, rental income, dividends from stocks/bonds, etc. – use additional paper, if needed)

a. _____ Monthly amount: _____

b. _____ Monthly amount: _____

c. _____ Monthly amount: _____

Checking Account Balance: \$ _____ Name of Bank _____

Savings Account Balance: \$ _____ Name of Bank _____

Year and Make of Automobile(s) _____ Loan Balance _____

Year and Make of Automobile(s) _____ Loan Balance _____

Stocks/Bonds (do not include 401(k) or tax-deferred IRA retirement investments) _____

House/Property Value _____ Loan Balance _____ Equity Amount _____

Other assets (please list with current market value – use separate sheet, if needed)

EXPENSES (monthly)

Rent/Mortgage _____ Water/Sewer _____ Food _____
Gas/Electric _____ Telephone _____ Clothing _____
Auto Payments _____ Pharmacy _____ Gasoline _____
Auto Insurance _____ Life Insurance _____ Health Insurance _____
Medical Expenses _____ Dental _____ Other (specify) _____

Creditor / Monthly Payment / Current Balance

Other expenses: _____

PERSONAL STATEMENT

To be written by applicant. If the applicant is between 13-18 years old, both the applicant and a parent should write separate statements. If applicant is less than 13 years of age, a statement from a parent is sufficient.

Please state how you think the cochlear implant will improve/enhance the life of the applicant socially, educationally, professionally, etc. You may use extra paper, if needed.

What are the expectations for the change in the applicant's hearing ability?

Relationship to applicant & name of person who wrote Personal Statement _____

RELEASE & VERIFICATION OF INFORMATION / UNDERSTANDING OF TERMS

I understand that the information submitted to CNI concerning annual income, family size, family assets, insurance, and medical history are subject to verification by CNI or their agents. I also understand that if the information I submit is found to be false, such a determination will result in elimination of my name from consideration for assistance. I further understand that the supply of cochlear implants for this program is limited and that the CNI Center for Hearing’s Cochlear Implant Assistance Program will submit a request to the manufacturer for an implant only if this application is approved following the review process. Availability of the cochlear implant will then be determined at the discretion of the manufacturer.

I further understand that, if I am approved via the Cochlear Implant Assistance Program, CNI will provide only the implant system itself and will not be responsible for any other fees associated with the cochlear implant procedure. I understand that I will be solely responsible for the payment of expenses which may include, but may not be limited to, the surgeon’s, audiologist’s, anesthesiologist’s, and hospital’s fees. I further understand that there will be ongoing expenses associated with the maintenance and performance of my cochlear implant and by signing below I am indicating my commitment to accept and manage those expenses.

Applicant’s Printed Name: _____

Signature (of Applicant or Parent): _____

Social Security Number: _____ Date: _____

Spouse’s/Partner’s Printed Name: _____

Signature of Spouse/Partner: _____

Social Security Number: _____ Date: _____

Father’s Printed Name (if applicant is a minor): _____

Signature: _____

Social Security Number: _____ Date: _____

Mother’s Printed Name (if applicant is a minor): _____

Signature: _____

Social Security Number: _____ Date: _____

MEDIA RELEASE (This section is optional and will not impact consideration for assistance.)

If requested, I agree to allow CNI to utilize video footage, photographs and/or our personal story regarding the cochlear implant process in publications or for media release at the discretion of CNI.

Printed Name: _____

Signature: _____

Date: _____

AUTHORIZATION TO RELEASE/REQUEST RECORDS/INFORMATION
(to be completed by patient or parent/guardian)

I authorize the Colorado Neurological Institute (501 c 3) Center for Hearing's Cochlear Implant Assistance Program to release/request records/information to/from the following as it pertains to my request to obtain a cochlear implant. My signature releases CNI to view and process all confidential medical information.

Cochlear Implant Team Coordinator: _____
Facility Name: _____
Phone: _____
Fax: _____
Email: _____

Cochlear Implant Surgeon/Practice: _____
Phone: _____
Fax: _____

Cochlear Implant Audiologist/Facility: _____
Phone: _____
Fax: _____
Email: _____

Hearing Aid Audiologist/Facility: _____
Phone: _____
Fax: _____
Email: _____

Primary Care or ENT Specialist: _____
Phone: _____
Fax: _____

Hospital/Surgical Center & Name of Contact Person: _____
Phone: _____
Fax: _____
Email: _____

Other (Parent, Spouse, Friend, Other – Please Specify): _____
Phone: _____
Fax: _____

Patient Name _____

Person authorized to sign for patient

Signature _____

Signature _____

Printed Name _____

Printed Name _____

Date of Birth _____

Relationship to Patient _____

Date _____

Date _____

AUTHORIZATION TO RELEASE/REQUEST RECORDS/INFORMATION
(to be completed by patient or parent/guardian)

I authorize the Colorado Neurological Institute (501 c 3) Center for Hearing's Cochlear Implant Assistance Program to release/request records/information to/from the following as it pertains to my request to obtain a cochlear implant. My signature releases CNI to view and process all confidential medical information.

Cochlear Implant Team Coordinator: _____
Facility Name: _____
Phone: _____
Fax: _____
Email: _____

Cochlear Implant Surgeon/Practice: _____
Phone: _____
Fax: _____

Cochlear Implant Audiologist/Facility: _____
Phone: _____
Fax: _____
Email: _____

Hearing Aid Audiologist/Facility: _____
Phone: _____
Fax: _____
Email: _____

Primary Care or ENT Specialist: _____
Phone: _____
Fax: _____

Hospital/Surgical Center & Name of Contact Person: _____
Phone: _____
Fax: _____
Email: _____

Other (Parent, Spouse, Friend, Other – Please Specify): _____
Phone: _____
Fax: _____

Patient Name _____

Person authorized to sign for patient

Signature _____

Signature _____

Printed Name _____

Printed Name _____

Date of Birth _____

Relationship to Patient _____

Date _____

Date _____

Colorado Neurological Institute (CNI)

Center for Hearing

Cochlear Implant Assistance Program

Statement of Agreement

(to be completed by Cochlear Implant Surgeon)

In accordance with the mission of the CNI Cochlear Implant Assistance Program, I agree that the no-charge cochlear implant system (internal component and speech processor), for which _____ **(patient's name)** is being considered as a donation recipient, will be used exclusively for him/her and for no other patient, and will not be retained nor sold nor given to any individual or organization for any other purpose.

I agree that the aforementioned patient will not receive any invoice nor will payment of any kind be required of the patient (or patient's family in the case of a minor) or any insurance carrier, for the cochlear implant system itself. I understand that this agreement pertains only to the implant system itself and does not necessarily reflect any financial arrangement regarding other fees including, but not limited to, surgeon's, audiologist's, hospital's, anesthesiologist's, or laboratory's fees associated with the cochlear implantation procedure. In accordance with the spirit of CNI Cochlear Implant Assistance Program's mission, I agree that attempts will be made to have associated fees waived or reduced to a level approximating the average Medicare reimbursement.

If the CNI Cochlear Implant Assistance Program agrees to award a no-charge implant system to the aforementioned patient, I agree that I or my designee will provide the scheduled surgery date information to the CNI Cochlear Implant Assistance Program not less than 21 days before the scheduled date and further agree that I or my designee will contact the program within 72 hours following the scheduled date of surgery to confirm the status of the procedure. If the surgery does not take place as scheduled, I agree that I or my designee will contact the CNI Cochlear Implant Assistance Program with that information, as stated above, and will then provide updates at intervals not to exceed 7 days regarding the delay and/or re-scheduling.

I agree to comply with the CNI Cochlear Implant Assistance Program and the device manufacturer's instructions in returning the donated implant system in its entirety, if the surgery of the aforementioned patient is cancelled or significantly delayed, at the discretion and request of the CNI Cochlear Implant Assistance Program. I agree to comply with the manufacturer's instructions regarding the return of any back-up device.

I have reviewed the patient's current insurance coverage (if any) and have confirmed that no portion of the cochlear implant procedure or the internal or external components are covered under his/her plan.

I agree that any claim or dispute arising out of the CNI Cochlear Implant Assistance Program shall be governed by the laws of the State of Colorado.

Signature of implant center representative

Printed name of implant center representative

Date

Telephone

Email

Name of Candidate: _____

REQUIRED ATTACHMENTS (please send these with the completed application)

Document Type:	Must Include:
A. Proof of Permanent, Legal US Residence (photocopy permitted)	1. Birth Certificate OR United States Passport OR Certificate of Naturalization (Form N550) OR a Green Card (Resident Alien Card). Note – If applicant is a minor, parent(s)/guardian(s) must submit proof for self(selves) as well as for the child
B. Income/Benefits (photocopy permitted)	1. Signed, dated, complete copy of previous year’s tax return 2. Past 3 months’ paycheck stubs or statement of social security/welfare payments of applicant and/or spouse/partner, or parent(s) if applicant is a minor
C. Insurance Documents (photocopies permitted)	1. Copy of front/back of insurance card of applicant 2. Complete insurance benefit booklet 3. Copies of all appeal and denial correspondence to/from insurance company – two documented denials/appeals are required
D. Auth. to Release / Request Information (original required)	1. Completed, signed Authorization to Release/Request Information (page 6 of application – please complete entire form)
E. Listing of Applicant’s Out-of-Pocket Expenses (excluding the cochlear implant system) (original req’d)	1. Complete listing from implant center on letterhead of <u>all expenses associated with procedure for which the applicant will be responsible</u> , including but not limited to: the surgeon’s, audiologist’s, anesthesiologist’s and hospital/surgical center’s fees
F. Implant Audiologist’s Summary (testing and all statements/reports must be within the last 12 months) (photocopy permitted of items 1-3; original of item 4 on letterhead required)	1. Audiogram to include: Unaided threshold & perception – for all applicants Aided: Adult – Aided threshold & perception; and HINT Sentences; or Children – Aided threshold & perception; and LNT Scores; or Infants – ABR & OAE 2. Etiology, type, onset & duration of deafness 3. Hearing Aid Report – when aided, current model/type of aids, current working status, consistency of use, current benefit of aids 4. Overall impression of applicant as CI user. Please include a summary of applicant’s/family’s expectations of results, any counseling regarding those expectations, motivation/commitment to rehab, etc
G. Surgeon’s Medical Summary (date of testing and assessment must be within the last 12 months) (photocopy permitted of items 1-3; original of item 4 on letterhead required)	1. Ear health/history 2. General medical history 3. CT Scan results (may be summarized as text in a report, letter or memo) 4. Overall impression of applicant as CI user. Please include a summary of physician’s expectations of results for the applicant, a statement of summary of treatment options for the applicant and a statement regarding the applicant’s/family’s insurance coverage, if any.
H. Surgeon’s Statement of Agreement (original req’d)	1. Completed, signed Statement of Agreement (page 7 of application). The original document must be submitted – please do not submit a photocopy.

**Please return completed form to:
CNI Cochlear Implant Assistance Program
701 E. Hampden Ave. #415
Englewood, CO 80113**

Please ensure that all copies of the required documents are sent with the original application.

Please keep a copy of all submitted documents for your own records.

Incomplete applications will not be considered. Applicants will be contacted if incomplete applications are received and will be given a maximum of 6 months during which all required documents must be submitted and received. Failure to provide all materials within 6 months will result in the application being classified as inactive and destroyed. If an applicant later wishes to be reinstated for consideration, all paperwork must be re-submitted under the guidelines in place at that time.

Disabled Children's Relief Fund

Disabled Children's Relief Fund (DCRF), a non-profit 501(c)(3) organization, provides disabled children with assistance to obtain wheelchairs, orthopedic braces, walkers, lifts, hearing aids, eyeglasses, medical equipment, physical therapy, and surgery. Blind, Deaf, Amputees, and children with Cerebral Palsy, Muscular Dystrophy, Spastic Quadriplegia, Encephalitis, Rheumatoid Arthritis, Spina Bifida, Down's Syndrome, and other disabilities receive assistance. DCRF focuses special attention on helping children throughout the U.S. that do not have adequate health insurance, especially the physically challenged. In some cases, DCRF may be the last resort. Applications are available between April and September. Applications can be retrieved online or by writing to:

Disabled Children's Relief Fund

Box 89

Freeport, NY 11520

<http://www.dcrf.com/orderze/Content/1/Summary.aspx>

Easter Seals

Easter Seals Nebraska, as part of a cooperative agreement with the Assistive Technology Partnership and First National Bank of Omaha, is able to offer alternative financing to qualifying Nebraskans with disabilities. These funds are available at a low interest rate, and specifically set for the purpose of purchasing approved equipment, assistive technology devices, and services. The Alternative Financing Loan Programs address two initiatives:

- Nebraska Alternative Financing Program provides low or reduced interest loans to qualified Nebraskans with disabilities for the purchase of assistive technology devices and assistive technology services. This includes, but is not limited to: wheelchairs, motorized scooters, Braille equipment, scanners, hearing aids, augmentative communication systems, environmental control units, computers, adaptive computer peripherals, building modifications for accessibility, motor vehicle modifications for accessibility, and motor vehicles requiring modifications for accessibility (where the value of the vehicle is greater than the cost of the modifications).
- Nebraska Telework Loan Program provides low or reduced interest loans to qualified Nebraskans with disabilities for the purchase of equipment and services necessary for securing Telework opportunities from home or other permanent remote sites. This includes but is not limited to: computers, printers, software, fax machines, scanners, office machines, telecommunication devices, telecommunication system installation charges, office furniture, home modifications for accessibility and/or to create home offices, motor vehicles, and other technology.

You can reach Easter Seals Nebraska at:

402-345-2200 (voice)

402-345-2500 (fax)

800-650-9880 (toll-free)

www.ne.easterseals.com

Easter Seals Nebraska

638 North 109th Plaza

Omaha, NE 68154-1722

First Hand Foundation

First Hand is a non-profit, 501 (c)(3) organization supported by the generosity of Cerner Corporation, its associates, its business partners, and friends. The Foundation assists individual children who have clinical, health-related needs and no financial safety net to cover these expenses. By focusing on the individual child, First Hand reaches children and their families who would otherwise fall through the cracks of insurance coverage and state aid. The Foundation strives to provide assistance that creates independence, rather than dependence for its recipients.

To be considered for funding, applicants must meet the following criteria:

- * The child must be 18 years of age or younger (a person 19–21 may be considered if they are in a child-like mental state)
- * The child must be under the care of a pediatrician
- * The case must involve a child with a specific healthcare need
- * The request must be clinically relevant to the health of the child
- * There must be no existing insurance coverage for the requested expenses
- * One request per year, per child for a maximum of three times in a child's lifetime

Expenses covered:

- * Treatment: Clinical procedures, medicine, therapy, prosthesis, etc.
- * Equipment: Wheelchairs, assistive technology equipment, care devices, hearing aids, etc.
- * Displacement: Lodging, food, gas, parking and transportation for families of seriously ill children who must travel during treatment
- * Vehicle modifications: Lifts, ramps and transfer boards

Expenses not covered:

- * Home modification projects
- * Alternative or experimental drugs, treatment or therapy where there is controversy in the medical community
- * Wheelchair-accessible van purchases
- * Requests for research funding, mass population grants or other nonprofit organizational grants
- * Requests for debt reduction/past medical bills
- * Copays or deductibles

Financial Guidelines

Clinical and Equipment guidelines:

Take your adjusted gross income minus out-of-pocket medical expenses for the child in the past year, and divide it by the number of dependent children in your family. The final outcome must fall between the following numbers:

Single child family \$0 - \$25,000
Multiple children family \$0 - \$20,000

Displacement guidelines

Annual income	Maximum grant per year
\$0 - \$19,000	\$1,000
\$19,001 - \$30,000	\$750
\$30,001 - \$45,000	\$500

\$45,001 and above \$0

Eligible travel expenses(related to treatment)

- * \$0.33 per mile for car expenses
- * Parking at cost indicated by social worker
- * \$10 a day per person for meals (maximum of two individuals)
- * Lodging at medical discount rate, ONLY if charitable housing is not available
- * Airfare at cost indicated by the family (with quote)

2800 Rockcreek Parkway

Kansas City, MO 64117

(816) 201-1569

<https://applications.cerner.com/firsthand/default.aspx>



Application for assistance

YOU MUST MEET THE FOLLOWING REQUIREMENTS BEFORE SUBMITTING AN APPLICATION:

- Income guidelines
- Age (18 or younger)
- Request (health care need)

Submittal checklist (documents needed will vary depending on the request)

- Application
- Signed release of information form
- Letter from doctor on letterhead that includes the child's diagnosis, history of illness, specific request for funding and other relevant information
- Letter of medical necessity from a social worker if requesting displacement assistance
- Letter from the provider on letterhead showing the original cost and estimated discount (discount must be given in order to receive assistance)
- First page of your most recent federal income tax return/W-2
- Letter of denial from the insurance company
- Child's photograph (this is not a requirement)

For questions regarding your application or the First Hand Foundation, please contact us at:

Phone: 816.201.1569

Fax: 816.571.1569

E-mail: firsthandfoundation@cerner.com

Web site: www.firsthandfoundation.org

Child's information

Last name _____ First name _____ Age _____ Birthdate (MM) _____ (DD) _____ (YYYY) _____
 Race _____ Citizenship _____ Male Female

Family's information

Mother's last name _____ First name _____ Occupation _____
 Address _____ City _____ State _____ Zip _____ Country _____
 Home phone _____ Cell phone _____ E-mail address _____
 Father's last name _____ First name _____ Occupation _____
 Address _____ City _____ State _____ Zip _____ Country _____
 Home phone _____ Cell phone _____ E-mail address _____
 Number of parents _____ Number of dependent children _____ Guardian of the child _____ Speak English? Yes No
 If no, primary language _____ Health insurance name (Private) _____ (Medicaid) _____
 Gross family income (prior year) \$ _____ Child Support \$ _____ SSI (U.S. only) \$ _____ Disability \$ _____
 Last year's out-of-pocket medical expenses for the child \$ _____ Amount requested from First Hand \$ _____
 Has funding been sought from additional sources? Yes No If yes, please list _____
 If funding has been received, from whom? _____ Amount \$ _____
 How did you hear about First Hand? Family _____ Friend _____ Social worker _____ Hospital professional _____ Internet _____ Other _____

Medical information (physician associated with current care)

Physician's last name _____ First name _____ Title (DO, MD, etc.) _____
 Social worker's last name _____ First name _____ Title _____
 Child's clinical diagnosis _____ Age at onset of illness _____
 Description of request _____ History of illness/health condition _____

Application continued

Complete the portion being requested. The First Hand Foundation reserves the right to distribute funds at its sole discretion. Please indicate exact address where funding will be sent to. First Hand will send money directly to the treatment provider, equipment company, hospital, etc., and not directly to the recipient family. A discount **MUST** be given for any request in order to be considered for funding.

Clinical request—services (surgeries, clinic visits, procedures, therapy, etc.)

Type of treatment _____
Number of treatments/visits _____ Cost per treatment/visit \$ _____ Discounted price \$ _____
If funding is granted, who will receive payment? (Company/provider) _____ Make to attention of _____
Address _____ City _____ State _____ Zip _____

Clinical request—medication

Name of medication _____ Dosage _____ Frequency _____
Number of months needed _____ Cost per month \$ _____ Discounted price \$ _____
If funding is granted, who will receive payment? (Provider/supplier) _____ Make to attention of _____
Address _____ City _____ State _____ Zip _____

Equipment/supply request

Type of equipment/supplies _____ Cost per equipment \$ _____ Discounted price \$ _____
If funding is granted, who will receive payment? (Provider/supplier) _____ Make to attention of _____
Address _____ City _____ State _____ Zip _____

Displacement request—travel

Must have official estimate and contact info for the transportation provider(s). Please check with Angel Flight or major airlines for assistance.

Purpose of travel _____ Transportation between which cities _____
Method of transportation: Plane Car Train Public transportation Estimated roundtrip mileage (if traveling by car) _____
Number of individuals _____ Number of roundtrips _____ Cost per adult \$ _____ Cost per child \$ _____
If funding is granted, who will receive payment (*funding will not be sent to family*)? (Company/Individual) _____
Make to attention of _____ Address _____ City _____ State _____ Zip _____

Displacement request—food

First Hand will provide \$10 per day for food (maximum of two individuals).

Number of individuals _____ Number of days needed _____ Does the hospital provide meal assistance/vouchers? Yes No
If funding is granted, who will receive payment (*funding will not be sent to family*)? (Company/Individual) _____
Address _____ City _____ State _____ Zip _____

Displacement request—lodging *Is charitable housing an option?* Yes _____ No _____

Number of individuals _____ Number of nights _____ Type of lodging _____ Discounted cost per night \$ _____
If funding is granted, who will receive payment? (Company) _____ Make to attention of _____
Address _____ City _____ State _____ Zip _____

Consent to release information and affirmation

REQUIRED—Consent to release information and affirmation

I do hereby authorize all hospitals, financial institutions and insurance groups to release to the First Hand Foundation, or its duly authorized representatives, any information deemed necessary to complete its investigation of my application for financial assistance. In addition, I do hereby authorize all hospitals, financial institutions and insurance groups to release to the First Hand Foundation, or its duly authorized representatives, any information or itemized statements that pertain to the diagnosis and treatment of the child and related expenses. I further authorize the First Hand Foundation and its representatives to provide such information to those institutions as may be reasonably required to assist our family and our child. All consents given herein shall continue until such time as the undersigned provides notice of termination in writing.

In order for First Hand Foundation, a non-profit organization to advance supplemental family support expenses in conjunction with the medical treatment of _____(child) the undersigned do hereby affirm as follows:

1. The undersigned are the parents or guardians of the child.
2. The term "non-medical expenses" is understood to mean lodging, food, gas, parking and transportation for children who require treatment incurred by the family or guardian of the above-named child in conjunction with that child receiving medical treatment. Financial assistance will be provided with the use of said funds to be specified by First Hand Foundation.
3. The undersigned further agree(s) to return any unused funds immediately to the First Hand Foundation so that those funds can be utilized by the organization to benefit other families.
4. The undersigned acknowledge(s) and agree(s) to maintain records that will be made available to the First Hand Foundation upon reasonable request, detailing the expenditures made from the funds provided by the organization.

The First Hand Foundation may pursue restitution for grants if it is determined that the information submitted on the application is false.

I have read the guidelines for financial assistance and I declare that the information furnished on this application form, including attached sheets, is true and correct to the best of my knowledge. (Please refer to the checklist at the top of page one of the application and attach all required documentation prior to submitting the application.)

When awarding a grant, the First Hand Foundation is not advocating for the specific health care providers or medical equipment suppliers, but only providing the funds to enable you to access the services and equipment. You acknowledge and agree that accepting a grant from the First Hand Foundation is strictly voluntary. Furthermore, you agree that you will be responsible for any choices you make regarding the medical care, equipment or supplies, or for the failure, malfunction, repairs or ongoing maintenance of any equipment obtained as a result of the grant of funds.

Dated this (Day) _____ day of (Month) _____, in the year (Year) _____

Mother/guardian signature _____ Please print name _____

Father/guardian signature _____ Please print name _____

Media release consent

I hereby give my permission for the First Hand Foundation and/or its representatives to use photographs, audio tape recordings, letters, information or videotape of my child or myself and to use our names, information, these images or voice recordings in publications, slides, videotapes, motion pictures or on the Internet.

I understand they will be used to inform families, volunteers, media and the general public about the First Hand Foundation and its programs, services or events. I gladly give this authorization to support the efforts of the First Hand Foundation. I understand this authorization shall continue until terminated in writing.

Signing the media release form is not a requirement in order to receive assistance from the First Hand Foundation

Child's name (please print) _____ DOB _____

Parent/guardian signature _____ Date _____

Address _____ City _____ State _____ Zip _____

HEAR NOW... Providing the Gift of Hearing (Starkey Foundation)

HEAR NOW assists individuals who are residents of the United States and qualify under the National Poverty Guidelines for assistance. Put simply: HEAR NOW is a domestic assistance program for people who otherwise wouldn't be able to afford hearing aids. The work of HEAR NOW is supported through the contributions of its many benefactors. HEAR NOW receives no government funding. All donations – monetary, time and hearing aids – allow the HEAR NOW program to survive and provide the gift of hearing.

Since 1995, HEAR NOW has provided more than 65,000 children and adults with hearing aids when they otherwise wouldn't have been able to afford them. It is truly awesome to help a man keep his job so he can support his family; to help a grandmother hear the precious voice of a grandchild; to assist a young mother hear her baby cry; and to make learning possible for a child in school.

HEAR NOW
6700 Washington Avenue South
Eden Prairie, MN 55344
1- 800-328-8602
<http://www.starkeyhearingfoundation.org/hear-now.php>

*Application available in Spanish

* Uso disponible en español



Dear Applicant,

Thank you for contacting the HEAR NOW Program of the Starkey Hearing Foundation for hearing aid assistance. Our hope is to provide hearing aids to those permanently residing in the U.S. who meet the criteria and are approved for assistance. The program is designed to assist those who have **no other resource** available to them. HEAR NOW is a program of last resort. Other options for assistance include: family support, insurance, state Medicaid program, vocational rehabilitation, school district, VA, church groups, state or local programs. Please call the HEAR NOW office to check your eligibility.

Assistance comes through manufacturer gifts, hearing health care providers in your area and donors across the U.S. The hearing health care provider is not reimbursed for his/her work with the HEAR NOW program. We deeply appreciate the time, effort and generosity they commit to HEAR NOW clients. We trust you will treasure the dedication and commitment of these generous individuals.

If the applicant has family support of **funds** available in money market accounts, mutual funds, 401(k) plans, IRAs, CDs (certificates of deposit), checking/savings accounts, stocks, bonds, T-bills or property, **this may not be the program for you**. Hear Now considers all these when determining eligibility. Only those who fall within the program guidelines for income, assets and hearing loss can be considered for assistance. The current non-refundable processing fee with the application is \$125 per hearing aid requested. The hearing health care provider will assist the applicant in determining the number of aids needed to help the applicant hear better. Every applicant is asked to call Hear Now to discuss their eligibility for the program. Please call 1-800-328-8602 (ask for Hear Now) to discuss this with a program representative.

The application/processing fee is non-refundable.

INFORMATION TO CONSIDER BEFORE COMPLETING THE HEAR NOW APPLICATION

- 1. Income Guidelines:** All income figures are NET. NET is the amount you actually receive in your check(s) regardless of source.

PERSONS IN FAMILY OR HOUSEHOLD	48 CONTIGUOUS STATES AND D.C.	ALASKA	HAWAII
1	\$19,058	\$23,800	\$21,945
2	\$25,743	\$32,165	\$29,628
3	\$32,428	\$40,530	\$37,310
4	\$39,113	\$48,895	\$44,993
5	\$45,798	\$57,260	\$52,675
6	\$52,483	\$65,625	\$60,358
7	\$59,168	\$73,990	\$68,040
8	\$65,853	\$82,355	\$75,723
EACH ADDITIONAL PERSON	\$6,685	\$8,365	\$7,683

- 2. Application and Order Processing Fee:** \$125 for one (1) aid **OR** \$250 for two (2) aids.

- 3. In determining eligibility, HEAR NOW considers the following:** all available funds, assets and hearing loss.

- a. Household Size** (Household is defined as those living together or dependent on each other).

- b. Net Monthly or Annual Income** from all in the household who have income. **Possible sources of income are:**

- Social Security and SSI
- Public Assistance
- AFDC
- Wages
- Interest from Stocks, IRAs, 401(k)s
- Alimony
- Disability
- Old Age Pension
- VA Pension
- Welfare
- Work Pension
- Black Lung Payments
- Child Support

- c. Assets** (include, but not restricted to)

- Checking
- Annuities
- Savings
- Stocks/Bonds
- Money Market Accounts
- IRA/401(k)
- CDs
- Burial Accounts
- Reverse Mortgage
- Home Equity Loan
- Property

HEAR NOW reserves the right to change eligibility criteria without prior written notice.

HOW TO COMPLETE THE PROCESS

1. Read the application completely.

2. Call Hear Now to discuss eligibility for the program.

- The number to call is 1-800-328-8602 (ask for Hear Now).
- Tell the representative you wish to discuss your eligibility for the program.

3. Find a hearing health care provider in your area who works with Hear Now.

- Hear Now does not provide referrals to local offices.
- Check your yellow page listings for Hearing Aids.

Choose offices closer to you.

- Make some calls to those offices to ask if anyone in that office works with the Hear Now program.
- Schedule an appointment for a hearing test .
- Have the practitioner complete pages 8 and 9 of the application.
- Obtain a copy of your hearing test results from the practitioner.

4. Complete pages 4, 5, and 6 --the applicant's signature is required on page 6.

5. Complete page 10 — either the primary physician signs the top portion of the page or the applicant can sign the bottom of the page.

6. Gather income information for all those in the household.

7. Gather copies of bank statements —

- Statements are needed for each account belonging to each individual in the household (most recent nine months).
A copy of each page of each statement is required (that includes the copies of the checks).

8. Gather the other necessary support documentation as outlined on page 5.

9. Include a Money Order or Cashier's Check for the processing fee (\$125 per aid) payable to Starkey Hearing Foundation.

(Personal checks are not accepted.)

10. DO NOT SEND ORIGINAL DOCUMENTS; THEY WILL NOT BE RETURNED TO YOU.

11. Mail all materials to:

Starkey Hearing Foundation
6700 Washington Ave. S.
Eden Prairie, MN 55344

12. Once you have mailed the application to HEAR NOW, please wait at least 5 weeks before making a call for a status check of your application.

*Additional information may be needed after initial review of the application.

**Hear Now reserves the right to change criteria at any time without prior written notice.

GENERAL INFORMATION

(Please Print Clearly)

Date: _____

Applicant's Name: First _____ Middle _____ Last _____

Date of Birth: _____ Age: _____ Social Security Number: _____ Male Female

Marital Status: Married Single Divorced Widowed Separated

Number in Household: _____ (Household is defined as all those living together or dependent on each other.)

Mailing Address:

Street _____ Apt. # _____

City _____ County _____ State _____ ZIP _____

Home Phone: _____ Work Phone: _____

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

Person, if other than applicant, completing this 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

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

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)

ADDITIONAL INFORMATION:

Applicant Name: _____

MARK 1 BOX FOR EACH ITEM. 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 9 months of current bank statements
Savings Account	<input type="checkbox"/>	<input type="checkbox"/>	If yes, provide all pages of 9 months of current bank statements
Credit Card	<input type="checkbox"/>	<input type="checkbox"/>	If yes, provide most recent statement
CD(s)	<input type="checkbox"/>	<input type="checkbox"/>	If yes, provide most recent statement
Stocks/Bonds	<input type="checkbox"/>	<input type="checkbox"/>	If yes, provide most recent statement
Annuity	<input type="checkbox"/>	<input type="checkbox"/>	If yes, provide most recent statement
IRA/401k	<input type="checkbox"/>	<input type="checkbox"/>	If yes, provide most recent statement
Money Market Account	<input type="checkbox"/>	<input type="checkbox"/>	If yes, provide most recent statement
Burial Account	<input type="checkbox"/>	<input type="checkbox"/>	If yes, provide 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
If you own your home, how much are your property taxes? _____			Send current statement.
Are you a Medicaid recipient?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	

HOUSEHOLD INFORMATION:

Household is defined as all those who live together or are dependent on each other.

Number in Household: _____

List names of individuals in household.

Name	Age of Person
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

Employment Status: Employed Other Retired

Name of Current Employer: _____

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

RELEASE OF INFORMATION

I understand the information I submit to HEAR NOW concerning my annual income, family size, family resources, insurance, medical history and all financial information are subject to verification by HEAR NOW and/or their agents. This verification will be done by phone, letter, e-mail 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.**

I understand the application/processing fee is non-refundable.

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 Minnesota shall govern the resulting transaction and any claim or dispute arising out of such transaction.



Dear Hearing Health Care Provider:

HEAR NOW, the US program of the Starkey Hearing Foundation, is committed to helping low income individuals who lack the resources to obtain needed hearing aids. Because the program works only with the help of generous, dedicated practitioners who care about the members of their community, your support of HEAR NOW clients is deeply appreciated. Practitioners are asked to waive their customary fees for fitting and follow-up for the first year of warranty coverage. You may assess your normal fee for the initial evaluation.

While interested practitioners are asked to donate their time and services to do the fitting and follow-up for the first year of warranty coverage, HEAR NOW provides the hearing aids to be fitted in your office. The Client Data Sheet (CDS) is an integral part of your client's application. An applicant's file is not complete without the CDS (pages 9 and 10). The application is reviewed when the Client Data Sheet, audiogram, Client Application and support documents are received in the HEAR NOW office. It is helpful if all documents are sent at the same time.

Practitioners willing to waive their customary fees for fitting and follow-up for the first year and are licensed to dispense hearing aids in their state are eligible to work with the program. It is necessary to have practitioner licensure information on record at HEAR NOW. Please provide this information on the Client Data Sheet and the hearing aid selection form for each client. If the client is approved for hearing aid assistance you will be contacted by HEAR NOW with instructions regarding the ordering process. It is preferable that impressions are kept in the practitioner's office until authorization to order aids/ earmolds is received from HEAR NOW.

HEAR NOW provides only BTE aids and RICs. Earmolds are provided to those who need them. All instruments provided through the program come with at least a one year warranty for repair. It is strongly recommended that extended warranty coverage for repair be purchased through the provider's office. Loss and Damage is not provided on Hear Now aids, but this coverage can be purchased through the provider's office.

The program has grown significantly over the years. It is expected that as the program continues to be discovered, the requests for assistance will continue to grow. Clients are asked to wait at least five (5) years before reapplying for new hearing instruments.

HEAR NOW reserves the right to change eligibility criteria at any time without written notice.

CLIENT DATA SHEET – MEDICAL/AUDIOLOGICAL INFORMATION

To be completed by the provider FITTING AIDS FOR CLIENT (Please Print Clearly)

Name of Client: _____ Date of Birth: _____

PLEASE ATTACH: Air and Bone Conduction Audiogram, SRTs, MCLs and UCLs

Is the client currently aided? YES NO If yes, list make/model and how old? _____

Number of aids requested: _____ **If fitting only one (1) ear,** which ear are you fitting? (check one)

LEFT RIGHT

I agree to become an associate of HEAR NOW for this client. I agree to provide services in accordance with state/federal guidelines. I understand that associates who receive hearing aids from HEAR NOW for their client agree to provide the services related to the fitting and follow-up without charge to the client for the first year of warranty coverage. HEAR NOW does not ask associates to waive any of their customary evaluation/hearing assessment fees. Charges related to the initial hearing evaluation are the client's responsibility.

PLEASE COMPLETE THIS SECTION FOR EACH CLIENT. THANK YOU.

Starkey Ship to Account #: _____ **OR Audibel** Ship to Account #: _____

Name of Professional: _____

Name of Business: _____

Address: _____

City: _____ State: _____ ZIP: _____

Phone: _____ Fax: _____

State Licensure/Registration #: _____

ASHA # _____ F-AAA # _____ IHS # _____ BC-HIS # _____

I do not have my CCC-A. Supervised by: _____ State #: _____

Signature: _____ Date: _____

E-mail: _____

HEARING AID SELECTION FORM

Name of Patient: _____ Date of Birth: _____

SHIP TO Acct #: _____ Currently wearing _____

Is this patient previously aided: YES NO

If only one aid, which side: LEFT RIGHT

Mark your selection for this patient in **ONE SECTION ONLY:**

_____ Analog A675 SSP	_____ Bone Conduction Aid
_____ Cros (Destiny ONLY) _____ Color	_____ Body Aid
_____ BiCros (Destiny ONLY) _____ Color	
_____ Standard Earmolds #	

_____ Genesis DX Trimpot Digital _____ Color (13 Battery only)
_____ Audidigital Trimpot Digital _____ Color (13 Battery only) (Audibel Dealers Only)
_____ Standard Earmolds #

_____ Destiny (circle choice) 400 800 1200 _____ Color _____ Battery Size
_____ Virtue (circle choice) 4 8 12 _____ Color _____ Battery Size (Audibel Dealers Only)
_____ Standard Earmolds # (SELECT ONLY 1) OR Slim Tubing SIZE _____ Ear Buds: Size _____

_____ S Series BTE (circle choice) 5 7 9 11 _____ Color _____ Battery Size
_____ S Series BTE Power 5 _____ Color _____ Battery Size
_____ Anthem (list level) _____ Color _____ Battery Size (Audibel Dealers Only)
_____ Standard Earmolds # (SELECT ONLY 1) OR Slim Tubing SIZE _____ Ear Buds: Size _____

_____ S Series BTE iQ (circle choice) 7 9 11 _____ Color _____ Battery Size
_____ Anthem (list level) _____ Color _____ Battery Size
_____ Standard Earmolds # (SELECT ONLY 1) OR Slim Tubing SIZE _____ Ear Buds: Size _____

_____ S Series RIC (circle choice) 5 7 9 11 _____ Color _____ Battery Size
_____ Anthem Plus (list level) _____ Color _____ Battery Size
_____ Receiver Length (circle choice) 1 2 3 4 5 _____ Color _____ Battery Size (Audibel Dealers Only)
_____ Receiver Gain (circle choice) 40 50 60 71 _____
_____ Standard Earmolds # (SELECT ONLY 1) OR Slim Tubing SIZE _____ Ear Buds: Size _____

_____ S Series RIC iQ (circle choice) 5 7 9 11 _____ Color _____ Battery Size
_____ Anthem Plus (list level) _____ Color _____ Battery Size (Audibel Dealers Only)
_____ Receiver Length (circle choice) 1 2 3 4 5 _____
_____ Receiver Gain (circle choice) 40 50 60 71 _____
_____ Standard Earmolds # (SELECT ONLY 1) OR Slim Tubing SIZE _____ Ear Buds: Size _____

Please send: _____ Software _____ Cables _____ Programming Boots
--

One of the following MUST be completed and submitted with the application.

MEDICAL CLEARANCE FOR HEARING AID USE

To be signed by client's Primary Physician

Date: _____

Patient Name (please print): _____

The patient listed above has been medically examined and may be considered a candidate for hearing aid use.

Physician Name (please print): _____

Physician Signature: _____

OR

WAIVER OF MEDICAL CLEARANCE FOR HEARING AID USE

To be completed and signed by the client

Date: _____

Client Name (please print): _____

I understand that it is in my best interest and recommended by HEAR NOW and the Food and Drug Administration to receive a medical examination before acquisition of hearing aids. I choose not to receive a medical examination before acquiring hearing aids.

Client Signature: _____

HIKE Fund

HIKE is a very special endowment fund, created in 1986 by the Job's Daughters International to provide hearing and/or assistive listening devices to children in need - Kids Helping Kids. Job's Daughters International is an organization for young women between the ages of ten and twenty who are related to a Master Mason.

Children under the age of twenty who have been identified as 1) having a need for a hearing aid or an assistive listening device and 2) having a financial need can benefit from HIKE. Applicants with a documented hearing loss are considered without regard to sex, race, religion, color, or creed. Each application is weighed on its own merit, and the application requires a letter from the applicant's family which is an important part of the application. Considerations include family income, size of household, burdensome medical expenses for the applicant, and the cost of the hearing technology requested.

Funds raised for HIKE are collected almost entirely by young women across the United States who are members of Job's Daughters - there are no salaried fund raisers!

The HIKE Fund, Inc.
c/o HIKE Board Secretary
10115 Cherryhill Pl
Spring Hill, FL 34608-7116
<http://www.thehikefund.org/>

APPLICATION INSTRUCTIONS

This application is a six (6) page document dated 3/11

1. Pages 1 and 2 of the application is the INFORMATION FOR PARENT/GUARDIAN to read and keep.
2. Pages 5 and 6 of the application is the INFORMATION FOR SUPPLIERS to read and keep.
3. Page 3 is the APPLICATION FOR HEARING AID(S) AND/OR ASSISTIVE LISTENING DEVICE(S) and must be filled out completely. You can fill in on-line and then print out.
4. Page 4 is the STATEMENT OF INCOME AND EXPENSES and must be filled out completely. You can fill in on-line and then print out.
5. Mail the following to the HIKE Board member listed on the bottom of page 2. Please send U.S. Regular or Priority Mail and DO NOT request a signature.
 - Completed pages 3 & 4
 - Letter from Parents/Guardian requesting Assistance
 - Copy of last years Federal Income Tax Return 1040 pages 1 and 2
 - Copy of recent pay stub(s) for each wage earner
 - Recent Audiogram
 - Itemized cost quotation from supplier
6. Within two weeks, the parent/guardian will receive a letter saying the application is complete or the application is incomplete and what is missing or the application is rejected and the reason for rejection.
7. If the application is complete, it will be sent to the HIKE Board Audiologist and, if approved, will be sent to the HIKE Board Treasurer.
8. The Board Treasurer will send a letter to parent/guardian giving the amount of the grant and approximately length of time before funds will be available.
9. When the funds are available, the awards check (made payable to the supplier) will be sent to a Job's Daughter representative in your area for presentation with a copy of the letter sent to Parent/Guardian. They will contact the Parent/Guardian to make arrangements for the presentation.



THE HIKE FUND, INC.

Hearing Impaired Kids Endowment Fund, Inc.

Supported by Job's Daughters International

INFORMATION FOR PARENT / GUARDIAN

HIKE is a very special endowment fund, created in 1986 by Job's Daughters International to provide hearing and/or assistive listening devices to children or institutions in need - Kids Helping Kids. Job's Daughters International is an organization for young women between the ages of ten and twenty who are related to a Master Mason.

Children under the age of twenty who are U.S. Citizens and have not received a previous HIKE Award within the last four (4) years and who have been identified as 1) having a need for a hearing aid(s) or an assistive listening device and 2) having a financial need can benefit from HIKE. Applicants with a documented hearing loss are considered without regard to sex, race, religion, color, or creed. Each application is weighed on its own merit, and the application requires a letter from the applicant's family which is an important part of the application. Considerations include family income, size of household, burdensome medical expenses for the applicant, and the cost of the hearing technology requested.

Funds raised for HIKE are collected almost entirely by young women across the United States who are members of Job's Daughters - there are no salaried fund raisers! With the guidance of their adult workers, Job's Daughters seek pledges for "hikes," sell baked goods, participate in rock-a-thons, sponsor dinners, and develop many other creative fund-raising ideas to support the work of the HIKE Fund.

For a child to be considered, the attached application must be completed. **This application must be accompanied by the following documents:**

1. A letter from the parent(s) or guardian(s) explaining the financial need
2. Statement of Income and Expenses
3. A copy of last years Federal Income Tax Return 1040 pages 1 & 2 and the most recent pay stub(s) from each wage earner (parents and/or guardians only)
4. A recent (not more than twelve (12) months old) audiogram AND quote from a licensed and/or certified audiologist and/or physician

" . . . that every child with joy may hear . . . " Blake

5. An itemized cost quotation from the supplier which should include cost of hearing aid(s) or device(s), cost of ear mold(s), professional fees (evaluation, fitting/dispensing fee, follow up visits, repairs/warranty per year, batteries, and insurance - loss or damage). **Please give your supplier the portion of this application entitled, "Information for Supplier".**
6. Please emphasize to your child's supplier that it is important to provide an address and telephone number in the space provided on the application form.

Submission of a single, all-inclusive information package allows the process to be completed in an efficient, timely manner. When all parts of the application have been received, consideration for approval begins. If any of the information described above is not included, this will delay consideration. You will be notified of the receipt of your application and of any additional information, if any, that will be required. Each application is reviewed initially for general content and subsequently is submitted to the HIKE Board's Audiologist for final review.

Please note that we are unable to accept applications for services or devices which have already been fitted.

The entire process of review, approval, and disbursement, depends upon the completeness of appropriate paperwork and the availability of funds for disbursement. You will be notified when the application has been approved and the funds are available. Many suppliers have elected to fit the child as soon as the family receives the notice from The HIKE Fund.

Following approval of an application, a check (payable to the supplier) will be sent to a representative of Job's Daughters for presentation to the recipient and his/her family. You will be contacted by a representative of Job's Daughters International to discuss a convenient time for the presentation.

If you have questions or would like to have assistance from a representative of Job's Daughters in your area, please contact:

**The HIKE Fund, Inc.
c/o Abbey Croissant
18 Cambridge Drive
Belleville, IL 62226
Phone: (618) 222-0936
E-mail: ajcroi@yahoo.com**



THE HIKE FUND, INC.

Hearing Impaired Kids Endowment Fund, Inc.
Supported by Job's Daughters International



APPLICATION FOR HEARING AID(S) AND/OR ASSISTIVE LISTENING DEVICE(S)

In order to be eligible a child must:

- * Be a U.S. Citizen
- * Have not received a previous Award
- * Be under twenty years of age in the past four (4) years

Name of Child: _____ Male <input type="checkbox"/> Female <input type="checkbox"/> DOB: _____ Age: _____	
Name of Parent or Guardian: _____	
Address: _____ City: _____ State: _____ Zip: _____	
Phone: Home _____ Work: _____ E-mail: _____	
Previous Award? <input type="checkbox"/> Yes <input type="checkbox"/> NO. If Yes, when _____	
Referring Physician and/or Audiologist : _____	
Practice: _____	
Address: _____ City: _____ State: _____ Zip: _____	
Phone: _____ FAX: _____ E-mail: _____	
Supplier _____:	
Address: _____ City: _____ State: _____ Zip: _____	
Phone: _____ FAX: _____ E-mail: _____	

ANY ITEMS NOT RECEIVED WILL DELAY THE APPLICATION PROCESS

SEND COMPLETED APPLICATION TO:

The HIKE Fund, Inc.
c/o Abbey Croissant
18 Cambridge Drive
Belleville, IL 62226
Phone: (618) 222-0936
E-mail: ajcroi@yahoo.com

PLEASE INCLUDE THE FOLLOWING:

- LETTER FROM PARENTS and/or GUARDIANS REQUESTING ASSISTANCE
- STATEMENT OF INCOME AND EXPENSES
- LAST FEDERAL INCOME TAX RETURN
- COPY OF RECENT PAY STUB
- RECENT AUDIOGRAM
- AN ITEMIZED COST QUOTATION FROM SUPPLIER

" . . . that every child with joy may hear . . . " Blake

STATEMENT OF INCOME AND EXPENSES

Name of Person completing this form: _____

FAMILY SIZE: No. of Wage Earners _____ No. Adults _____ No. Children _____

Please attach a copy of last years Income Tax Return and the most recent pay stub(s) from each wage earner.

MONTHLY INCOME:

Salary/Wages	\$ _____
Public Assistance (welfare, food stamps, etc).	_____
Social Security benefits	_____
Rental Income	_____
Investment Income	_____
Alimony/child support	_____
All other sources of income or Assets	_____
_____	_____
Total INCOME from all sources:	\$ _____

MONTHLY EXPENSES:

Mortgage/rent Payment(s)	\$ _____
Automobile/other vehicle payments	_____
Utilities	_____
Clothing	_____
Insurance (Health/Life/Auto)	_____
Other health care payments	_____
Other _____	_____
Other _____	_____
Other _____	_____
Total EXPENSES	\$ _____

Are You Awaiting Funding From Another Source? _____ If YES, What Amount \$ _____

From What Organization? _____

The financial information provided above is, to the best of my knowledge, accurate and complete. It includes total monthly income from all sources.

Applicant, Applicant's Parent/Guardian

Date

" . . . that every child with joy may hear . . . " Blake



THE HIKE FUND, INC.

*Hearing Impaired Kids Endowment Fund, Inc.
Supported by Job's Daughters International*

INFORMATION FOR SUPPLIERS

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Children under the age of twenty who are U.S. Citizens and have not received a previous HIKE Award in the past four (4) years and who have been identified as having a need for a hearing aid(s) and/or an assistive listening device(s) can benefit from HIKE. Applicants with a documented hearing loss are considered without regard to sex, race, religion, color, or creed. Each application is weighed on its own merit, and the application requires a letter from the applicant's family which is an important part of the application. Considerations include family income, size of household, burdensome medical expenses for the applicant, and the cost of the hearing technology requested.

Funds raised for HIKE are collected almost entirely by young women across the United States who are members of Job's Daughters - there are no salaried fund raisers! With the guidance of their adult workers, Job's Daughters seek pledges for "hikes," sell baked goods, participate in rock-a-thons, sponsor dinners, and develop many other creative fund-raising ideas to support the work of the HIKE Fund.

Dedicated individuals from throughout the United States serve without compensation on the Board of Directors. Proudly, our operating expenses have historically been less than five percent of total income. In recognition of this service and our designation by the Internal Revenue Service as a 501(c)(3) organization, some suppliers have provided equipment at discounted rates and others have waived portions or all of their usual, customary fees.

THE APPLICATION PROCESS:

HIKE Bylaws require that the supplier submit a cost quotation which is itemized and includes, but is not limited to, the following information:

1. Cost of hearing aid(s) and/or assistive listening device(s)
2. Cost of ear mold(s)
3. Batteries
4. Professional fees (evaluation; fitting/dispensing; follow-up, per visit)

" . . . that every child with joy may hear . . . " Blake

5. Repair warranty, per year
6. Insurance for loss and/or damage
7. Other items

The quotation must be submitted on official letterhead and should include the name of a contact person who is familiar with the applicant's case. When possible, it is helpful to list phone numbers for the contact during daytime or early evening hours, as some inquiries are done after normal business hours.

Please give this quotation to the parent or guardian making the request to include with other documents required for application. Submission of a single, all-inclusive information package allows the process to be completed in an efficient, timely manner.

Each application is reviewed initially for general content and subsequently is submitted to the HIKE Board's Audiologist for final review. If the Board Audiologist has questions concerning the quotation you may be contacted.

Please note that we are unable to accept applications for services or devices which have already been fitted.

THE AWARD PROCESS:

The entire process of review, approval, and disbursement depends upon the completeness of appropriate paperwork and the availability of funds for disbursement. The family of the recipient is notified immediately when the application has been approved, and many suppliers have elected to fit the child as soon as the family receives the notice from The HIKE Fund.

Following approval of an application, a check (payable to the supplier) will be sent to a representative of Job's Daughters for presentation to the recipient and his/her family.

Thank you in advance for your cooperation in submitting the necessary information for the cost quotation. Applications are processed as quickly as possible so that, to the fullest extent possible, no child in need will go without assistance. If you wish to contact the HIKE Board's Audiologist, e-mail: audiologist@thehikefund.org or please contact The HIKE Secretary (352) 688-2579.

". . . that every child with joy may hear . . ." Blake

Kids Connection

Kids Connection is health care coverage for qualified children developed by the State of Nebraska. It includes both the Children's Health Insurance Program (CHIP) and the Nebraska Medical Assistance Program (also known as Medicaid).

Kids Connection provides well care for your child in helping to prevent diseases, finding and treating problems early, and maintaining good health and development

Regular check-ups include:

- baby checkups and immunizations
- immunizations for school-age children
- yearly checkups for school-age children, including school and sports physicals
- dental check-ups and dental sealants
- vision and hearing testing

Your child's eligibility to have health coverage through Kids connection is based primarily on your family's income.

Children may be eligible:

- if they are under age 19
- if they live in Nebraska
- even if both parent live at home
- even if one or both parents work full-time
- even if their family already has some type of health insurance*

*When you apply for Kids Connection, your children will be evaluated for enrollment based on your income. Some programs under Kids Connection are not available to children who have health insurance.

*Apply online at:

http://dhhs.ne.gov/Children_Family_Services/AccessNebraska/Pages/accessnebraska_index.aspx

*Application available in Spanish

* Uso disponible en español

Nebraska Department of Health & Human Services Finance & Support

P.O. Box 95026

Lincoln, NE 68509-5026

Phone: 1-877-632-5437 or 402-471-8845

http://dhhs.ne.gov/medicaid/Pages/med_kidsconx.aspx

Application for Children's Medical Programs

Effective June 1, 2005



Kids Connection

Instructions: Read carefully. Please write clearly.

*Required field

This is not a valid application until it contains your name, address and signature.

IF YOU OR YOUR CHILDREN ARE RECEIVING OR HAVE APPLIED FOR MEDICAID DO NOT FILL OUT THIS FORM

*Person Applying for the Child or Children		*Relationship	Social Security Number (if available)		
*Address (Number, Street)	*City	*Zip Code	*County	*Telephone/Home or message phone	
Mailing Address, if different (Number, Street)		City	Zip Code	Telephone/Work	

Did anyone in your household receive services through the Department of Health and Human Services this month or last month?

(For example: Food Stamps, ADC, Child Care, Medicaid, Energy Assistance, etc.)

Yes No

If yes, explain under what name, where, when and type of services:

*What is the primary language spoken in your household?

List everyone in your family who lives with you (parents & children). Give the information listed. Use more paper if you need to.

*Name: (First Name, Middle Initial, Last Name)	U.S. Citizen Legal Alien Y/N	Social Security Number	Race	Birthdate (m/d/yyyy)	Sex M/F	*Pregnant Y/N	*If Pregnant, What is Expected Due Date? Provide doctor's statement	
Parents in Home (Biological, step or adoptive) Include Pregnant Minors								
*Children	*U.S. Citizen Legal Alien Y/N	*Social Security Number	Race	*Birthdate (m/d/yyyy)	*Sex M/F	*Mother's Name	*Father's Name	*Attend School Y/N

Do you currently have insurance? Yes No If yes, tell us the name of your insurance company, the policy number and the names of everyone covered on the policy. The cost of health insurance premiums may be deductible from countable income.

*Insurance Company	*Phone Number of Company	*Policy Number or Group Plan Number	*Type of Coverage (HMO, full coverage, vision, etc.)	*Names of Family Members covered by Policy

Did any of your children living with you have unpaid medical bills in the past 3 months? Yes No
If yes, you may be able to receive help paying these bills.

Attach Copies of Pay Stubs and Complete Information Below

We need proof of your income. For earnings, provide copies of **PAY STUBS FOR THE LAST FULL MONTH**. If you do not have pay stubs, you may provide a letter from your employer. If you are self employed, provide a copy of your most recent federal income tax return. Other documents can be used, such as a letter from your employer. If you have questions, call toll-free at 1-877-632-5437.

Does any Adult or Child Currently Receive any Money From:	No	Yes	*If Yes Who Is It?	*Employer Name or Income Source	*Gross Amount	*How Often Received?
Salaries, Wages, Tips, Commissions, etc., (Provide pay stubs for each adult)						
Self-Employment Income - (Include 1040 and appropriate Schedules)						
Unearned Income Such As: Veteran's Benefits, Child Support/Alimony, Spousal Support, Interest, Dividends						
Unearned Income Such As: Unemployment Compensation, Worker's Compensation, Social Security, SSI					58	

If you pay day care costs, please give names of the children and the monthly amount you pay for each child.

*Name of Child	*Monthly Amount	*Name and Address of Provider

Do you want to receive Information about additional help with: (check applicable boxes) Money Food Utilities Rent/Shelter Child Care Transportation Adult Care Help in your Home Other _____

PLEASE SIGN THIS STATEMENT: I certify that the information I have provided above is true to the best of my knowledge and I give permission for the State of Nebraska to make any necessary contacts to check my statements. I have read the list of my rights and responsibilities that is printed below. I know that I could be penalized if I knowingly give false information. I certify that the children listed on this application are U.S. citizens or legally admitted aliens.

*Signature or Mark of Applicant: _____ *Date: _____
(Witness if mark)

**Mail this completed, signed form, together with proof of income, to:
Kids Connection, P.O. Box 94926, Lincoln, NE 68509-4926.**

If you need more information, please call the toll-free number 1-877-NEB-KIDS (1-877-632-5437) or 402-471-8845.

Rights and Responsibilities

If you need assistance with food, utilities, day care or other needs contact your local Department of Health and Human Service Office.

- I know that my children under age 19 who are eligible for Medicaid/Kids Connection can have free health checkups under a child health prevention program called Health Check (EPSDT).
- I know that the information I have given is confidential. I agree that medical information about my children can be released only if needed to administer this program.
- I know that any information I have given may be reviewed and verified by the State of Nebraska. Also, I understand that I must cooperate fully with state and federal workers if my case is reviewed. No additional permissions are needed to get verification or other information.
- I know that this application will be considered without regard to race, color, sex, age, handicap, religion, national origin or political belief.
- I know that I may ask for a hearing if I am not satisfied with any action taken by the State of Nebraska in connection with the program. I may also ask for a hearing if I feel that I have been discriminated against.
- I know that the State of Nebraska will request and use information from a computer system called the State Income and Eligibility Verification System (IEVS). This computer system compares the Kids Connection information about me and other members of my family with information from other agencies. Other agencies may include the Internal Revenue Service, Social Security Administration, Department of Labor, Veterans Administration and Vital Statistics.
- I know that Kids Connection does not pay medical expenses that a third party, such as a private health insurance company, is supposed to pay if my children get Kids Connection. I give my rights to any third party payments to the Department of Health and Human Services. These payments may include payments from hospital and health insurance policies. I know that if I refuse to give my rights to third party payments to the Department of Health and Human Services, I will not be eligible to receive Medicaid.

I understand that this application is an application for one kind of children's health benefits under Medicaid and is not a full Medicaid application. I understand that if my children are not found eligible for this children's health benefits program under Medicaid, I may be eligible for Medicaid benefits on some other basis and have a right to complete a full Medicaid application.

Income Computation:

FOR AGENCY USE ONLY

- | | |
|---|--|
| 1. Total Monthly Gross Earned Income \$ _____ | 4. Subtract \$100 from Line 3 for each employed adult \$ _____ |
| 2. Total Net Self-Employment Income \$ _____ | 5. Total Child Care Costs \$ _____ |
| 3. Total Earned Income (Add lines 1 & 2) \$ _____ | 6. Net Earned Income (Subtract 5 from 4) \$ _____ |
| | 7. Total Monthly Unearned Income \$ _____ |
| | 8. Total Countable Income (Add 6 & 7) \$ _____ |

NEBRASKA HEALTH AND HUMAN SERVICES SYSTEM



The Nebraska Health and Human Services System promotes and values diversity. It is committed to affirmative action/equal employment opportunities and does not discriminate in delivering benefits or services.

Medicaid

Nebraska Medicaid covers hearing aids, hearing aid repairs, necessary batteries, and supplies. There are limitations on hearing aid services. Please contact Health and Human Services for more information.

Nebraska Department of Health and Human Services

P.O. Box 95044

Lincoln, NE 68509-5044

(402) 471-2306

Local Service Contacts

Western Nebraska--Gering (800) 477-6393

Central Nebraska--Grand Island (800) 892-7922

Southeast Nebraska--Lincoln (877) 213-4754

Northern Nebraska--Norfolk (888) 704-0180

Southwest Nebraska--North Platte (800) 778-1600

Omaha area-- (402) 595-2120

Medically Handicapped Children's Program

This Program provides access to specialty evaluations that provide a diagnosis and medical treatment plan prior to the family making a financial application. The evaluations may be provided with select specialty providers and/or one of the specialty clinics for children and youth.

Specialty clinics for children and youth are teams which consist of specialty physicians, nutritionists, nurses, occupational therapists, physical therapists, psychologist, dentists, speech and hearing pathologists, and the family. The teams meet all at one time and in one place. Team membership depends upon the particular medical conditions being reviewed. The most important member of the teams is the family. Teams provide diagnosis of the medical concerns and problems, a written plan of treatment, and access to all the team members at one time and place.

The Program can provide services for the following and other congenital and severe conditions:

The Program's medical director reviews the medical information and makes the eligibility decision.

- *Asthma* -- severe and persistent.
- *Orthopedic conditions* -- including scoliosis, rheumatoid arthritis, club foot, bow legs, leg length discrepancy and fractures that have not healed properly and have become chronic conditions.
- *Eye conditions* -- which may be corrected through surgery.
- *Hearing loss* which is severe.
- *Hemophilia*
- *Major medical* -- A 'catch all' term which includes many congenital and chronic conditions including: acute severe burns, neurological conditions, ill premature births, urology, Addison's disease, Turner's syndrome, sickle cell disease, hypothyroidism, esophageal strictures, imperforate anus, Hirschsprungs, disease growth hormone deficiency, and other conditions.
- *Neoplasm* -- cancers, tumors, lymphoma and leukemia.
- Other conditions which may be severe and chronic and/or congenital.

Nebraska Department of Health and Human Services

P.O. Box 95044

Lincoln, NE 68509-5044

(402) 471-2306

http://dhhs.ne.gov/Pages/hcs_programs_mhcp.aspx

Local Service Contacts

Western Nebraska--Gering (800) 477-6393

Central Nebraska--Grand Island (800) 892-7922

Southeast Nebraska--Lincoln (877) 213-4754

Northern Nebraska--Norfolk (888) 704-0180

Southwest Nebraska--North Platte (800) 778-1600

Omaha area-- (402) 595-2120

Miracle-Ear® Children's Foundation

Miracle-Ear® Children's Foundation provides free hearing aids and services to children from low-income families.

For Hearing Aid Fitting Applications

To receive assistance through the Children's Foundation:

- * Applicants must be 16 years of age or younger and have a hearing loss that requires amplification
- * Applicants must complete an application form and provide an audiogram and medical clearance dated within the last 6 months.
- * Applicants must have an income level which does not allow the family to receive public support. \$20,000 - \$50,000 gross.
- * Applicants must possess a family commitment to intervention, rehabilitation, and necessary follow-up services as the child grows
- * Applicant must be live in the U.S. or Puerto Rico. Applications will be sent to U.S. addresses only. The name and address of the child's parent or guardian are required for application requests. Supplemental contact information (phone numbers and email addresses) may also be helpful in turning around information requests.

You may also request information by calling the Miracle-Ear® Children's Foundation directly at 1-800-234-5422.

<http://www.miracle-ear.com/childrenrequest.aspx>



CONFIDENTIAL APPLICATION/ SOLICITUD CONFIDENCIAL

MISSION STATEMENT

Working with Miracle-Ear® Centers across the nation, the non-profit Miracle-Ear Children's Foundation provides hearing aids, follow-up care and services to children from qualified families, free of charge.

The Miracle-Ear Children's Foundation also helps to educate families about hearing loss and how it affects children.

DECLARACIÓN DE LA MISIÓN

Al trabajar con Miracle-Ear® Centers en toda la nación, la Miracle-Ear Children's Foundation, una organización sin fines de lucro, proporciona aparatos auditivos, atención de seguimiento y servicios gratis a los niños de familias que reúnen las condiciones.

Asimismo, la Miracle-Ear Children's Foundation ayuda a educar a las familias acerca de la pérdida auditiva y cómo ésta afecta a los niños.

Date/Fecha _____

Name of Hearing-Impaired Child/Nombre del niño con discapacidad auditiva _____

Name of Parent/Guardian/Nombre del padre/tutor _____

Address/Dirección _____

City/Ciudad _____ State/Estado ____ Zip/Código postal _____ County/Condado _____

Telephone/Teléfono: Home/Casa (_____) _____ Work/Trabajo (_____) _____

Child's Birthdate/Fecha de nacimiento del niño _____ M F

School and Grade/Escuela y año escolar _____

Parent/Guardian Employer/Empleador del padre/tutor: _____

Spouse's Employer (if married)/Empleador del cónyuge (si es casado): _____

Present hearing aid user?/¿Usa un aparato auditivo actualmente? Yes/Sí No/No

If yes - date, year received/Año en que lo recibió _____

If yes - make and model for hearing aids. /Si usa - marca y modelo de los aparatos auditivos. _____

Present FM/AudioTrainer user? /¿Usa actualmente un FM/Audio Trainer?

If yes - make and model./Si usa - marca y modelo. _____

Were you ever provided hearing aids by the Children's Foundation?/¿Alguna vez Children's Foundation le ha proporcionado aparatos auditivos? Yes/Sí No/No

If yes, date/En qué fecha _____

Have you applied for assistance to purchase hearing aids through public or community programs?/¿Ha solicitado asistencia para comprar aparatos auditivos a través de programas públicos o de la comunidad?

Yes/Sí No/No

If yes, list contacts—attach letter if declined (example: County Health/Social Services, Community Clinics, Children's Medical Services, Programs for Amplification for Children, other) _____

En caso de haberla solicitado, escriba los contactos. Adjunte la carta si se la negaron (ejemplo: de Servicios Sociales/de Salud del Condado, Clínicas de la Comunidad, Servicios Médicos para Menores, Programas de Amplificación para Niños, otros) _____

Other persons living in home/Otras personas que viven en su casa

1. Name/Nombre _____ 2. Name/Nombre _____

Age/Edad _____

Age/Edad _____

Relationship/Parentesco _____

Relationship/Parentesco _____

Monthly Income \$/Ingreso mensual \$ _____

Monthly Income \$/Ingreso mensual \$ _____

Source of Income/Fuente del ingreso _____

Source of Income/Fuente del ingreso _____

Total Family Income/Ingreso familiar total: _____

Number of persons dependent on this income/Número de personas que dependen de este ingreso:

Ages/Edades: _____, _____, _____, _____, _____, _____, _____, _____

How much does your household have in checking/¿Cuánto dinero tiene su unidad familiar en cuenta de cheques? \$ _____, cash/En efectivo \$ _____, savings/En ahorros \$ _____

Account Number(s)/Número(s) de cuenta(s): _____

Name and address of bank(s)/Nombre(s) y dirección(es) del (los) banco(s): _____

Confidential Financial Information/Información Económica Confidencial

The Miracle-Ear Children’s Foundation’s purpose is to provide hearing aids and services to those children whose parents cannot afford to purchase them. Eligibility for hearing aids and other services requires that you provide complete financial information for you and your family members residing in the same household.

El propósito de Miracle-Ear Children’s Foundation es proporcionar aparatos y servicios auditivos a los niños cuyos padres no tienen posibilidades económicas para comprarlos. Las condiciones que se deben reunir para obtener aparatos y otros servicios auditivos requieren que proporcione información económica completa acerca de usted mismo y de sus familiares que vivan en la misma casa que usted.

A. Sources and Amounts of Monthly Gross Income/Fuentes y cantidades de ingreso bruto mensual

Employment/Empleo	\$ _____
Social Security/Seguro Social	\$ _____
SSI (Supplemental Security Income)/ SSI (Ingreso de Seguridad Suplemental)	\$ _____
Disability/Discapacidad	\$ _____
GA (General assistance)/ GA (Asistencia General)	\$ _____
Pension/Retirement/Pensión/Jubilación	\$ _____
Dividends/Interest/Dividendos/Interés	\$ _____
Other (annuity, trust fund, child support, rental property)/Otros (anualidades, fondos de fideicomiso, manutención de menores, propiedad alquilada)	\$ _____
Total Monthly Income/ Ingreso mensual total	\$ _____

B. Monthly expenses/Gastos mensuales:

Housing/Vivienda	\$ _____
Do you own your own home/ ¿Es usted dueño de su casa?	<input type="checkbox"/> Yes/Sí <input type="checkbox"/> No/No
Utilities (phone, water, gas, electric)/ Servicios públicos (teléfono, agua, gas, electricidad)	\$ _____
Food/Alimentos	\$ _____
Insurance (auto, home, life, health)/ Seguro (de vehículo, casa, vida, salud)	\$ _____
Transportation (public and/or gas)/ Transporte (público y/o gasolina)	\$ _____
Direct medical expenses/ Gastos médicos directos	\$ _____
Credit card/loan payments/ Pagos de tarjetas de crédito/préstamos	\$ _____
Other expenses (please list, use additional page if necessary)/Otros gastos (por favor escriba una lista; use otra página si es necesario)	\$ _____
	\$ _____
	\$ _____
	\$ _____
	\$ _____
Total Monthly Expenses/ Gastos mensuales totales	\$ _____

C. Disposable Income/Ingreso disponible:

Total (A) Less Total (B)/ Total (A) menos total (B)	\$ _____
--	-----------------

I acknowledge that all resources have been exhausted in trying to seek hearing help for my child. I hereby certify that to the best of my knowledge the above statements are true and correct, and I authorize the Miracle-Ear Children's Foundation to verify this information. I also understand that any statement which is found to be false may result in my disqualification from the services offered by the Miracle-Ear Children's Foundation.

Afirmo que he agotado todos los recursos en la búsqueda de ayuda para la audición de mi hijo. Por la presente certifico que a mi mejor saber y entender, las declaraciones anteriores son verdaderas y correctas y autorizo a Miracle-Ear Children's Foundation a que verifique esta información. También, entiendo que si se determina que cualquier declaración es falsa, podría resultar en que se me descalifique de los servicios ofrecidos por Miracle-Ear Children's Foundation.

Signature/Firma: _____ Date/Fecha: _____

Social security #/Núm. de Seguro Social: _____

NOTE: A physician's medical clearance (enclosed) and audiogram must accompany the application. Both the medical clearance and audiogram must be dated within the last 6 months. If they do not accompany the application, the processing time will be delayed by at least 2 weeks after the additional information is received.

NOTA: Debe presentar la autorización médica de un médico (adjunta) y un audiograma junto con la solicitud. Tanto la autorización médica como el audiograma deben tener fecha no anterior a los últimos 6 meses. Si no los presenta junto con la solicitud, se retrasará el trámite por lo menos 2 semanas una vez recibida la información adicional.

In Emergency Contact/En caso de emergencia, llamar a:

Name/Nombre: _____

Relationship/Parentesco: _____ Phone/Teléfono: (_____) _____

Address/Dirección: _____



P.O. Box 59261
Minneapolis, MN
55429-0261
1-800-234-5422
Fax: 763-268-4295

Nebraska Children's Hearing Aid Loaner Bank and HearU Nebraska Fund

How can I obtain a loaner hearing aid for my child?

- Must be a current resident of Nebraska and under the age of 19
- Hearing evaluation must be performed by a licensed Audiologist.
- Audiologist can contact the loaner bank at nchalb@unlnotes.unl.edu or call us at (402) 472-0043 to gain access to application forms and current inventory.
- Parent/Guardian & Audiologist complete application form and fax or mail completed application to the address listed on the form.
- Upon approval, hearing aid(s) are sent to the Audiologist within 7 days of receiving completed application.
- Hearing aids are loaned to you for a period of 6 months.
- If you have not secured personal amplification for your child within 6 months or are awaiting cochlear implant surgery, loan extensions may be available.

<http://www.unl.edu/barkley/nchalb/>

Nebraska Children's Hearing Aid Bank/HearU Nebraska
University of Nebraska-Lincoln
Barkley Memorial Speech, Hearing & Balance Clinic
Room 202
Lincoln, NE 68583
Phone: (402) 472-0043

Nebraska Children's Hearing Aid Bank & HearU Nebraska
APPLICATION FORM

The intent of both the Nebraska Children's Hearing Aid Bank & HearU Nebraska is to provide hearing aids and/or audiological services for children who otherwise would not be able to afford these services. We ask that you only apply for this program if the needed hearing aids and/or audiological services are not fully covered by another source and would produce an undue financial hardship for your family. Your consideration will ensure that the greatest number of children will be served through these programs.

Please complete parts A-D of this application and mail or fax to:

Nebraska Children's Hearing Aid Bank/HearU Nebraska
University of Nebraska-Lincoln
Barkley Memorial Speech, Hearing & Balance Clinic
Room 202
Lincoln, NE 68583
Phone: (402) 472-0043 **Fax: (402) 472-3814**

Program Director: Stacie Ray, Doctor of Audiology **(402) 472-2075**

The information contained on this form will be kept confidential.

PART A – To be completed by the referring audiologist

Referring Audiologist Information

Audiologist's Name: _____

Practice Name: _____

NE Audiology License #: _____

Mailing Address: _____

Phone Number: _____ Fax Number: _____

Child's Information

Name: _____ Date of Birth: _____

Parent/Legal Guardian's Name: _____

Mailing Address: _____ Residential Address: _____

Phone Number: _____ Alternate Phone: _____

E-mail Address _____
Alternate Contact: _____

PART B

To be completed by the referring audiologist

In order for this request to be processed, please confirm that the following have been completed:

- _____ Audiometric testing (please send copy of test results)
- _____ Medical clearance
- _____ Signed parent agreement form

Was this child referred to you based upon the failure of the Universal Newborn Hearing Screening protocol? Yes _____ No _____

If yes, from which hospital? _____

What is the configuration (if known) and degree of hearing loss?

Is this a binaural or monaural fitting? _____

Please indicate using the list below the make, model and color of hearing aid that you would recommend for this child, numbering preferences 1-3. While we cannot guarantee the exact make and model, please be assured that every attempt will be made to match your request.

- 1. _____
- 2. _____
- 3. _____

The hearing aid(s) will be sent to the requesting audiologist within 7 days of receiving the application and required documentation. The hearing aid will be selected and sent by the Hearing Aid Loaner Bank based on the information received.

Audiologist Signature

Date

PART C

To be completed by the parent or legal guardian

1. Please provide a brief statement indicating the reason assistance from the loaner bank is requested. (Please describe why you cannot provide immediate access to hearing aids for your child)

2. Do you currently have insurance coverage to secure permanent hearing aids for your child? If yes, have you contacted your insurance company to apply for hearing aids? Please indicate the insurance company name, and the status of your contact.

3. Are you currently eligible for Medicaid or Kid's Connection? If yes, have you contacted Medicaid/Kid's Connection to approve payment for the hearing aids?

4. Do you need information regarding resources to secure permanent hearing aids?

Signature of Parent/Legal Guardian

Date

PART D

HEARING AID AGREEMENT

_____ I agree that my child will receive (a) loaned hearing aid(s) from the Nebraska Children's Hearing Aid Bank

_____ I agree to provide a brief statement indicating the reason assistance is requested.

_____ I agree that it is my responsibility to maintain and care for the hearing aid(s) and that I will be responsible for any loss or damage not covered by the hearing aid warranty up to \$100.00. This excludes normal wear and tear.

_____ I agree that my child will have use of this/these hearing aids(s) for the extent of the loan period which will be clearly outline I will complete a renewal or extension application if required.

_____ I agree that if for any reason my child no longer uses the hearing aids, or qualifies for benefits that provide hearing aids through insurance, I will return the loaned hearing aid(s) to my child's audiologist, to be returned to the loaner bank.

_____ I agree to release my child's hearing loss information to the Nebraska Children's Hearing Aid Loaner Bank, Nebraska's Early Hearing Detection and Intervention Program, Early Development Network and my local Regional Program.

Please provide the following demographic information for your child (check all that applies):

_____ Male

_____ Female

Origin:

_____ Spanish/Hispanic/Latina(o)

_____ Mexican

_____ Puerto Rican

_____ Cuban

_____ Other (specify) _____

Race:

_____ White

_____ Black or African American

_____ American Indian/Alaska Native (specify)

_____ Asian Indian

_____ Chinese

_____ Filipino

_____ Other Pacific Island (specify)

_____ Other (specify) _____

_____ Japanese

_____ Korean

_____ Vietnamese

_____ Other Asian (specify)

_____ Native Hawaiiin

_____ Guananian or Chamorro

_____ Samoan

Parent/Legal Guardian Signature

Date

Nebraska Specialized Telecommunications Equipment Program (NSTEP)

The State of Nebraska is proud to present the Nebraska Specialized Telecommunications Equipment Program (NSTEP). The goal of this program is to provide monetary assistance to persons with disabilities. These persons will then use the financial assistance to aid in the purchasing of specialized telephone equipment such as amplifiers, signaling devices and TTY/TTs.

The Nebraska State Legislature established the Nebraska Equipment Distribution Program during the 1995 legislative session. The Public Service Commission (PSC) was mandated to develop specific procedures necessary for implementation of the program and is responsible for management of the program.

In 1999, the legislature passed a bill that removed the income guideline requirement. The equipment distribution program will issue a voucher of up to \$1,000 to deaf, hard of hearing, deaf-blind, and speech disabled persons.

Vouchers can only be used to purchase specialized telecommunication equipment.

A voucher will be issued to approved applicants for the purchase of telecommunication equipment. The equipment can be purchased from any merchant selling the specialized devices. Coordinators for NEDP can provide a list of vendors distributing the specialized telecommunication equipment. The vendor can provide installation and training on the use of the equipment. Additional training assistance is available through the Nebraska Commission for the Deaf and Hard of Hearing.

Types of Equipment You Can Receive

- CapTel®
- TTY
- Signaling Devices
- Built-In Amplified Telephone
- Cordless Built-In Amplified Telephone
- Telephone Amplifier - In-Line Telephone Amplifier
- Voice Carry Over (VCO) Telephone
- Speech-Impaired Amplified Telephone
- Computer Conversion Package
- Large Visual Display
- Tactile Ring Signaler
- Telebrailer

Selection of Equipment guidelines (Section B on application):

1. You may check only one box in Part 1. If your selection does not match one of those categories, check the box marked "Other" and please specify your selection. Remember only specialized telephone equipment can be selected. In other words it must be related to the use of the telephone and specially designed for deaf, hard of hearing, visual and hearing or speech disabilities.

2. You may check only one box in Part 2. This part allows you to select a signaling device. You may choose either a visual, audible or tactile ring (vibrating) signaler. For visual ring signalers, a maximum of only 2 remote receivers are allowed.

Eligibility guidelines (Section C on application):

1. You must have a hearing, visual and hearing, visual or speech disability which prevents you from using the phone effectively;
2. You must be three years of age or older, and can demonstrate the ability to use the equipment;
3. You have phone service or have applied for phone service in the state of Nebraska at your place of primary residence;
4. You are a current resident of the state of Nebraska;
5. Only one person per household may be a recipient of the telecommunications equipment;
6. A recipient of equipment may not reapply for assistance more than once every five years.

Your completed application form may be sent to any of the following locations:

Nebraska Commission for the Deaf and Hard Of Hearing - Lincoln
4600 Valley Road Ste. #420
Lincoln, NE 68510-4844

Nebraska Commission for the Deaf and Hard Of Hearing - Omaha
1313 Farnam On-The-Mall
Omaha, NE 68102-1836

Nebraska Commission for the Deaf and Hard Of Hearing – North Platte
200 South Silber, Rm 207
North Platte, NE 69101-4298

Nebraska Commission for the Deaf and Hard Of Hearing – Scottsbluff
PO Box 1500
Scottsbluff NE 69363-4907

Nebraska Public Service Commission
300 The Atrium, 1200 N Street
P.O. Box 94927
Lincoln, NE 68509-4927

<http://www.ncdhh.ne.gov/nstep.html>

Application for the Nebraska Specialized Telecommunications Equipment Program

A.

(Please Print)

APPLICANT INFORMATION

NAME: _____
(Last) (First) (Middle Initial)

HOME ADDRESS: _____
(Number and Street Name, or PO Box) (Apt #)

CITY: _____ STATE: _____ ZIP: _____ COUNTY: _____

DAYTIME PHONE: () _____ V/TTY/Both HOME PHONE: () _____ V/TTY/Both
(Circle One) (Circle One)

SOCIAL SECURITY NUMBER: _____ - _____ - _____ BIRTH DATE: _____ / _____ / _____
(Mo) (Day) (Yr.)

Name of someone who can help us contact you: (a person not living with you). NOTE: If mail address is different than the applicant's address, complete this section and check this box .

NAME: _____ TELEPHONE: () _____ V/TTY/Both
(Circle One)

ADDRESS: _____ CITY: _____ STATE: _____ ZIP: _____

B.

EQUIPMENT NEEDS

Part 1 – Telephone Equipment - (Please Check Only One)

- CapTel (Captioned Telephone)
- Computer Conversion Package (TTY modem only)
- Phone with Amplification (Built-in)
- Phone Amplifier
- TTY/TT (with 6 rolls of paper maximum)
- Voice Carry Over (VCO) Phone
- Other (please specify) _____

Additional application required:
 Tactile Ring Signaler (severe hearing & vision disability)
 TTY and Large Visual Display or /Telebrailleur (severe hearing & vision disability)

Part 2 – Phone Signaling Devices – (Please Check Only One)

- Light Signaler Phone Ring - One Signaler
_____ Number of remote receivers needed (Limit of 2)
- Phone Ringer
- Personal Signaler (vibrating device)
- Other (What Kind –example, "Alertmaster") _____

Check if Setup is required:

C.

ELIGIBILITY

- | | | |
|--------------------------|--------------------------|---|
| Yes | No | |
| <input type="checkbox"/> | <input type="checkbox"/> | I have a hearing, visual and hearing loss, or speech disability which prevents me from using the telephone effectively. |
| <input type="checkbox"/> | <input type="checkbox"/> | I am three years of age or older, and can demonstrate the ability to use the equipment. |
| <input type="checkbox"/> | <input type="checkbox"/> | I now have phone service or have applied for phone service in the state of Nebraska at my place of residence. |
| <input type="checkbox"/> | <input type="checkbox"/> | I am a current resident of the state of Nebraska. |
| <input type="checkbox"/> | <input type="checkbox"/> | Have you ever applied for this program? If yes, approximate month and year ____/____ |

The above facts are true and complete to the best of my knowledge.

X _____ DATE _____
(Applicant or Guardian's Signature if applicant is under 18 years of age)

PROFESSIONAL CERTIFICATION

(to be completed by certifier)

I certify this applicant as one of the following:

- Deaf Hard of Hearing Speech Disability Deaf-Blind (includes severe hearing & vision)

(check one of the following and provide appropriate information)

- Assistive Technology Project Representative (ATP)
 Audiologist or Licensed Hearing Aid Dispenser
 Augmentative Speech Pathologist
 Center for Independent Living Representative
 Licensed Physician/Assistant
 Nebraska Commission for the Deaf and Hard of Hearing (NCDHH)
 Services for the Visually Impaired Representative (SVI)
 Speech Pathologist
 Vocational Rehabilitation Representative (VR)
 Other _____

This individual requires other adaptive equipment (specify): _____

(Please Print)

NAME: _____

AGENCY NAME: _____

ADDRESS: _____

CITY: _____ STATE: _____ ZIP: _____

TELEPHONE: () _____ FAX: () _____

E-MAIL ADDRESS: _____

X _____ DATE: _____
(Certifier's Signature) (Title)

INTERNAL USE ONLY

Approved

Denied

COMPLETED BY: (Please Print)

NAME: _____ AGENCY: _____

ADDRESS: _____

CITY: _____ STATE: _____ ZIP: _____

PHONE NUMBER: () _____

E-MAIL ADDRESS: _____

X _____ DATE: _____
(NEDP Coordinator's Signature) 75

United States Citizenship Attestation Form

For the purpose of complying with Neb. Rev. Stat. §§ 4-108 through 4-114, I attest as follows:

I am a citizen of the United States.

— OR —

I am a qualified alien under the federal Immigration and Nationality Act, my immigration status and alien number are as follows:

_____ ,
and I agree to provide a copy of my USCIS documentation upon request.

I hereby attest that my response and the information provided on this form and any related application for public benefits are true, complete, and accurate and I understand that this information may be used to verify my lawful presence in the United States.

PRINT NAME:

(First)

(Middle)

(Last)

SIGNATURE: _____ Date: _____

Project Endeavor

Project Endeavor is a program of CSD, funded by a two year contract with the National Telecommunications and Information Administration (NTIA) as part of the American Recovery and Reinvestment Act (ARRA). This program focuses on providing deaf and hard of hearing Americans with access to broadband or high speed internet through discounted internet service plans and internet devices. Project Endeavor also provides an array of training materials and educational resources for deaf and hard of hearing people.

Eligibility requirements:

- Deaf or Hard of Hearing with a bilateral hearing loss of 40db or greater
- age 16 or above
- a U.S. citizen or hold a U.S. Permanent Resident Card
- and at least one of the following
 - a Transition Plan Student or an active Vocational Rehabilitation client
 - currently enrolled in a Public Assistance program
 - yearly household income less than the Project Endeavor guidelines

Project Endeavor / CSD

102 North Krohn Place

Sioux Falls, SD 57103

Voice: 1 (877) 638-6377

AIM Screenshot: CSDPE1, CSDPE2, CSDPE3

Videophone: (605) 550-4056

Fax: (605) 782-8446

Email: info@projectendeavor.com

<http://www.projectendeavor.com/Home.aspx>



Apply Today!

Personal Information

Last Name _____ First Name _____ Middle Initial _____

Street Address _____ City _____ State _____ Zip _____

Telephone number (____) _____ Email Address _____

What is the best way for us to contact you? (Phone, VP, Text, Email, Mail, Other) _____

Daytime contact number _____ Evening contact number _____

Ethnicity (Optional)

Caucasian/White Latino African American/Black Native American Pacific Islander Asian Other _____

Eligibility

Are you a U.S. Citizen or a permanent resident of the U.S.? Yes No Year of Birth _____

Are you currently enrolled in a public-assistance program? Yes No **If yes, please check all that apply.**

- Medicaid Low Income Home Energy Assistance (LIHEAP)
- Supplemental Security Income (SSI) or SSDI Federal Public Housing Assistance or Section 8
- National School Lunch's Free Program (NSL) Food Stamps or SNAP (Supplement Nutrition Assistance Program)
- Women, Infants and Children Program (WIC) Temporary Assistance for Needy Families(TANF) or Welfare to Work (WTW)

Are you a Transition Plan Student or an active Vocational Rehabilitation client? Yes No **If yes, which?**

Transition Plan Student (High School Student) Vocational Rehabilitation Client (Active)

Household Information

How many person(s) in your family household? _____ What is your total annual household income? _____

Affirmative Signature

Hearing Loss Verification (bilateral hearing loss of 40db or greater)

With my signature, I confirm that I am deaf hard of hearing or deaf-blind

Signature of applicant _____ Date: _____

With my signature above I hereby request services and certify that the information I have provided in this application is true and accurate to the best of my knowledge. I acknowledge that I am subject to audit and if I am found providing inaccurate information on this form, I will be prosecuted to the fullest extent allowable by law. Should I become eligible for services, I agree to use these services solely for the purposes intended. I further understand that I may not sell, mortgage, lend or transfer interest in any equipment or services provided to me. If I receive any refund for returned equipment or canceled services paid for by Project Endeavor I agree to return this funding to the Project. Falsification of any records or failure to comply with these provisions will result in the immediate termination of service. Note: Applications submitted by eligible individuals under the age of 18 must be co-signed by a parent or legal guardian.

CSD is committed to ensuring that your privacy is protected. Information provided on this application form will only be used to determine eligibility for Project Endeavor products and services. We will not sell, distribute or lease your personal information to third parties unless we have your permission or are required by law to do so. We are committed to ensuring that your information is secure. In order to prevent unauthorized access or disclosure, we have put in place suitable physical, electronic and managerial procedures to safeguard and secure the information we collect.

Referral

I was referred to Project Endeavor by:

Application Party Tradeshow Internet Person (Name _____) Other

Return Information

Return this form to: **Mail:** CSD--Project Endeavor • 102 N Krohn Place • Sioux Falls, SD 57103

Please allow 2 weeks for processing if submitted by mail. You will be contacted by a member of the Project Endeavor team, who will further process your qualification. To expedite your process, please use fax or email:

Fax: 605-782-8446 **E-mail:** info@projectendeavor.com



Project Endeavor is made possible through the Broadband Technology Opportunities Program with the National Telecommunications and Information Administration. www.ntia.doc.gov

Small Steps in Speech

The mission of Small Steps in Speech is to help children with speech and/or language disorders take the steps needed to be better communicators. This is achieved through grants and donations to service providers and qualifying charitable organizations.

About our Grants

We understand that children are unique and so are the services/treatments needed to improve their communication. We are open to awarding grants to cover a variety of communication needs whether it is geared towards a child or a charitable organization. An applicant may only apply for a grant once a calendar year unless they can provide proof that the need (financial, medical, developmental, etc) has changed. If the person nominating the applicant is not the parent or legal guardian, the parent or legal guardian must be notified by the person nominating the applicant as part of the application process. If the person nominating the applicant is the parent/legal guardian, and interested in the grant paying for private speech therapy, the therapy provider and therapist must be notified of you applying for the grant as we may be contacting them.

Application Process

Applications are reviewed and distributed on a quarterly basis by the board of directors. If additional information is needed to complete the application, it could delay the application review by the Board. When appropriate, awarded grants are sent to third party professional service providers after completion of a contract for services on behalf of the child/organization. No more than four grants per individual therapy provider will be dispersed within one calendar year. If a grant is given for private speech therapy, the speech language pathologists must be licensed within the United States of America.

Grants are awarded to individuals from birth up to the age of 22 years. The services/treatments requested cannot be received before the grant is awarded. The application must request a specific need in regards to a communication delay/disorder. If the request or need changes, the Board can withdraw the current application before its review and the applicant can re-apply.

Small Steps in Speech

P. O. Box 134

Collingswood, New Jersey 08108

Applications may also be faxed to (856) 632-7741

<http://www.smallstepsinspeech.org/index.php>



Grant Application

Small Steps in Speech
P. O. Box 134, Collingswood, New Jersey 08108
1-888-5SPEAK6 (888-577-3256) info@smallstepsinspeech.org
Fax: 856-632-7741
www.smallstepsinspeech.org

Thank you for your interest in applying for a grant from *Small Steps in Speech*, a not for profit 501(c)3 foundation created in memory of Staff Sgt. Marc J. Small.

The Board of Directors will review and provide grants or aid to such organizations and/or individuals in accordance with our guidelines and policies. The foundation shall be operated exclusively for charitable, and/or educational purposes as permitted by law.

Applications are reviewed and grants are awarded on a quarterly basis. Grants are considered for children and/or organizations that need funding to improve communication skills. Grants are not limited to private therapy. If there are communication needs such as devices/equipment, workshops, organizational needs, or therapy we encourage you to apply. If applying for a grant to be used toward an assistive technology device, an assistive technology evaluation from a qualified service provider must be included. Funding for AT devices will only be considered if the device is recommended by such a provider and to be used solely for the purpose of communication.

Please remember to enclose the following with your application:

- Current evaluations and/or reports regarding the applicant's speech and language development. Evaluations should be on professional letterhead (school IEP's can be used)
- Documentation/Copy of insurance providers name along with the explanation letter from insurance provider stating amount of speech therapy sessions allowed per calendar year, deductible or copy of the denial letter from insurance company.
- Copy of most recent IRS 1040 form.
- Contact information to the facility (name, address, phone number) where you will be using the monies from the grant. It is the nominee's responsibility to find a service provider before an application can be considered complete. Therapy providers and therapists must be informed that you are applying for a grant through their facility as we may be contacting them.



Grant Application

Part I. Child Family History

Date: _____

Child's Name: _____ Date of Birth of Child: ____ / ____ / ____

Parent/Caregivers Name: _____

Home Address: _____

City: _____ State: _____ Zip Code: _____ County: _____

Primary Phone Number (Include Area Code): _____

Family Email Address: _____

Primary Language Spoken in the Home: _____

Parental Place of Employment (father): _____

Address of Employment: _____

City: _____ State: _____ Zip: _____

Parental Place of Employment (mother): _____

Address of Employment: _____

City: _____ State: _____ Zip: _____

Child's Primary Mode of Communication: _____

Diagnosis of Child: _____

Grade level of Student: _____

Name of Attending School or Treatment Facility: _____

Number of siblings living in the home: _____

Annual Household Income

_____ Under \$30,000

_____ \$30,000 - \$49,999

_____ \$50,000 - \$74,999

_____ \$75,000 - \$99,999

_____ \$100,000 and over

_____ Copy of Recent IRS 1040 form

* Are there photos enclosed in this application? _____ Yes _____ No

* Are there videos enclosed in this application? _____ Yes _____ No

*Photographs and videos are reviewed solely by the Board of Directors to understand the child's condition, and have no other influence on the grant decision. All photos/videos become property of SSIS and may be used for promotions/events (personal information will not be distributed) Photographs and videos will not be returned.



Grant Application (continued)

Part II. Person Nominating a Child

Check here if information is the same as Part I and proceed to Part III

Name: _____

Home Address: _____

City: _____ State: _____ Zip Code: _____ County: _____

Primary Phone Number: _____

Email Address: _____

Relationship to Applicant: _____

Place of Employment: _____ Years Employed: _____

Address of Employment: _____

City: _____ State: _____ Zip: _____

Part III. Professional Service Provider Information

On a separate page, please provide the following:

- a. Name of Professional Service Provider with whom you would like to receive an evaluation and/or services (if applicable). It is the nominee's responsibility to find a service evaluator/provider before an application can be considered complete. Ensure that they are aware that you are applying for a grant through Small Steps in Speech as someone may be contacting them.
- b. Provide a copy of the last two statement bills (if applicable) from therapy provider on professional letterhead.
- c. Recommendations for treatment- attach most recent report (school IEP can be used) on provider letterhead. Include contact information and your intention/vision of how the grant money would be used for the intended individual/charitable organization.

Part IV. Applicant's Story

Using no more than 500 words, please provide relevant information on the child/organization as it relates to communication disorders. The information can include, but is not limited to, how treatment will improve the applicant's daily life, how treatment will help the long term outlook of the applicant and/or how the treatment will affect the family's quality of life. Also consider providing information about the personality traits, prognosis in therapy, treatment history and treatment goals of the applicant. Please tell us why this is important to everyone involved.



Grant Application (continued)

Part V. How Did You Hear About *Small Steps in Speech*?

Part VI. Additional Coverage

1. Is the applicant receiving assistance from insurance? _____ Explain: _____

(Provide name of insurance provider and a copy of the insurance explanation of benefits letter in regard to speech and language therapy.)

2. Is the applicant currently receiving private speech services? If yes, please explain where, how often and what type of setting (individual/group/in-class/consultation)

3. Does the applicant currently receive intervention in the school system? _____ If yes, how often and what type of setting (individual/group/in-class/consultation). If no, and over the age of 3.0 years please explain rationale for not receiving school based speech therapy. _____

4. What will the funding from SSIS pay for specifically (What will the money be used for?)

5. Does the applicant receive any other funding from other sources including any other grants, family support, scholarships, etc? If so explain past and present support: _____



Grant Application (continued)

Privacy and Terms of Use

The *Small Steps in Speech* Foundation respects your rights of privacy. Your privacy is important to us. The information received by the *Small Steps in Speech* Foundation will be used solely to determine awarding a charitable grant. We will not sell your e-mail address to anyone or share your personal information with anyone other than a representative of the foundation. Please be advised that your photos may be used for promotional purposes. Although the company has taken reasonable precautions to ensure no viruses are present in this e-mail, the company cannot accept responsibility for any loss or damage arising from the use of this e-mail or attachments. We use personal information to pursue the mission of the *Small Steps in Speech* Foundation. All information shall be used for a lawful purpose. You agree that all information provided to the *Small Steps in Speech* Foundation is truthful and accurate. Any attempt to provide false information will result in the dismissal of the application. The applicant will be removed from consideration of any grants from *Small Steps in Speech* in the future. If a grant is awarded based on false information it could result in legal action against the person nominating the child. Submission of any personal information constitutes an agreement to the *Small Steps in Speech* Foundation's Privacy and Terms of Use Policy.

You agree to indemnify, defend and hold harmless the *Small Steps in Speech* Foundation, from and against any and all losses, damage, liability and cost of every nature incurred by them in connection with any claim, damage or loss related to or arising out of any assistance or services provided, any alleged breach or breach by you of these terms. You agree to cooperate fully in the defense of any of the foregoing. From time to time the *Small Steps in Speech* Foundation may amend the Privacy and Terms of Use Policy, all amendments shall be effectively immediately. *Small Steps in Speech* does not discriminate against race, gender or religion.

WE DO NOT GUARANTEE THE SECURITY OF PERSONAL INFORMATION OR OTHER INFORMATION IN ANY FORM. PLEASE DO NOT PROVIDE OR ALLOW OTHERS TO PROVIDE PERSONAL INFORMATION ABOUT ANYONE UNLESS YOU, ON YOUR OWN BEHALF AND ON BEHALF OF ANYONE WHO'S INFORMATION YOU PROVIDE, ARE AUTHORIZED TO DO SO.

TO THE FULL EXTENT ALLOWED BY LAW, YOU AGREE THAT THE *SMALL STEPS IN SPEECH* FOUNDATION WILL NOT BE LIABLE TO YOU OR ANYONE ELSE FOR ANY SPECIAL, CONSEQUENTIAL, INCIDENTAL OR PUNITIVE DAMAGES, DAMAGES FOR LOST PROFITS, FOR LOSS OF PRIVACY OR SECURITY, FOR LOSS OF REPUTATION, FOR FAILURE TO MEET ANY DUTY (INCLUDING BUT NOT LIMITED TO THE DUTY OF GOOD FAITH OR LACK OF NEGLIGENCE OR OF WORKMANLIKE EFFORT), OR FOR ANY OTHER SIMILAR DAMAGES WHATSOEVER THAT ARISE OUT OF OR ARE RELATED TO ANY ASPECT OF THE APPLICATION AND INFORMATION DISCLOSED.

With your signature you agree to the Privacy and Terms and give Small Steps in Speech permission to contact all related service providers as mentioned in the application.

Signature of Person Applying for Grant

Date

Signature of Parent/Legal Guardian

Revised October 2011

Sorenson Video Relay

Sorenson Video Relay Service (VRS) is a free service for the deaf and hard-of-hearing community that enables anyone to conduct video relay calls with family, friends, or business associates through a certified ASL interpreter via a high-speed Internet connection and a video relay solution (or VRS call option). You can use a Sorenson videophone to make VRS calls to hearing individuals and point-to-point calls to other deaf individuals.

Deaf or hard-of-hearing individuals who use sign language to communicate can receive a free Sorenson VP-200 videophone. To apply, visit the Sorenson website. After application, the Sorenson VRS sales team will first check to make sure that:

1. The application has been completely filled out
2. The deaf or hard-of-hearing individual has a high speed Internet connection of at least 256K
3. An installer is available to set up the videophone for the deaf or hard-of-hearing individual

Due to the high demand for the free Sorenson VP-200 videophone, it can sometimes take several weeks for a videophone to be installed. Please note that the free Sorenson videophone is available for deaf and hard-of-hearing individuals who primarily use American Sign Language (ASL) to communicate.

Sorenson Communications
4393 South Riverboat Road, Suite 300
Salt Lake City, Utah 84123
(801) 287-9400
<http://www.sorensonvrs.com/apply/>

TPA SCHOLARSHIP TRUST FOR THE DEAF AND NEAR-DEAF

In 1975 the Travelers Protective Association of America (TPA) established a scholarship trust for the deaf and near deaf. The intent and purposes of the trust are the giving of financial aid or assistance to residents of the United States or its possessions who suffer deafness or hearing impairment and who will benefit from medical, mechanical or specialized treatment, or special education and who are unable to provide funds therefore for themselves.

Application for charitable assistance must be submitted on the approved trust application form by an adult, or if a minor, by the person having legal custody of the candidate.

The selection and amount of aid granted to a candidate shall be decided by the majority of the full Board of Trustees or the full Trust Executive Committee. Applicants may re-apply annually.

The trust is supported by gifts, bequests, and devises that are obtained from individuals, businesses, trusts, corporations, other entities, and from accretion of investment of the trust's funds. Because of the limited funds available, financial aid is usually a one-time nonrecurring disbursement.

At present distributions are issued from accretions of investments from the trusts funds. Applicants demonstrating the greatest financial need are given preference regardless of race, creed or sex.

For further information concerning the trust:

TPA Scholarship Trust

Board of Trustees

3755 Lindell Blvd.

St. Louis, MO 63108

<http://www.tpahq.org/scholarshiptrust.html>



SCHOLARSHIP TRUST FOR THE HEARING IMPAIRED

3755 LINDELL BOULEVARD
ST. LOUIS, MO 63108-3476
(314) 371-0533 • (314) 371-0537 FAX.
www.tpahq.org • support@tpahq.org

sponsored by The *Travelers Protective Association*

GENERAL GUIDELINES

OF

THE TPA SCHOLARSHIP TRUST FOR THE HEARING IMPAIRED

The objects and purposes of this Trust in general are the giving of financial aid or assistance to residents of the United States or its' possessions who suffer deafness or hearing impairment; who will benefit from medical, mechanical, specialized treatment or specialized education and who are unable to provide the funds therefore themselves.

The funds necessary to effectuate the above shall be obtained from tax deductible gifts, bequests and devises obtained from individuals, firms, trusts, corporations, other entities and from accretions of investments to the Trust funds.

Applications for charitable assistance must be submitted on the approved Trust application form by adults or if a minor, by the person having legal custody.

Approved Trust applications shall be submitted to the Board of Trustees or in the interim between annual meetings to the Trust Executive Committee.

The selection of recipients of Trust scholarships and the amount thereof shall be within the sole discretion of the Board of Trustees or the Trust Executive Committee.

The selection and amount of aid shall be granted only upon concurrence of a majority of the full Board of Trustees or full Trust Executive Committee.

In all cases, the Declaration of Trust and Bylaws thereof shall be followed and complied with in full.



**APPLICATION FOR AID FROM
T.P.A. SCHOLARSHIP TRUST
FOR THE HEARING IMPAIRED**
3755 Lindell Boulevard, St. Louis, Missouri 63108-3476



Full Name of Applicant: _____
Last First Middle

1. Residence Address: _____
Street City State Zip

2. Birth Date: _____ Place of Birth: _____

Telephone Number: _____

If Applicant Is A Minor

Name of Parent or Guardian: _____
Last First Middle

3. Address: _____
Street City State Zip

4. If Guardian, Type of Guardian: Natural Parent _____ Court Appointed _____

5. Occupation of Applicant: _____

If a Minor, Applicant's Parents Occupation: _____

6. Name of Employer: _____

If a Minor, Applicant's Parents Employer: _____

7. Annual Income from Employment: _____

8. Annual Income from Other Sources: _____

Identify other sources and amounts:

(a) _____ \$ _____
Amount

(b) _____ \$ _____
Amount

(c) _____ \$ _____
Amount

11. Dependents of Applicant (Give names, relationship, ages and address)

If a Minor, Applicant's Parents:

_____	_____	_____	_____
Name	Relationship	Age	Address

_____	_____	_____	_____
Name	Relationship	Age	Address

_____	_____	_____	_____
Name	Relationship	Age	Address

_____	_____	_____	_____
Name	Relationship	Age	Address

12. School information:
School applicant attending: _____
Grade: _____ Public: _____ Private: _____
Approximate tuition costs annually: _____
Financial assistance from other sources: _____

13. What insurance does applicant have: (Include only major medical, medical pay and Blue Cross-Blue Shield)

(a)	_____	_____
	Name of Company	Type of Coverage
(b)	_____	_____
	Name of Company	Type of Coverage
(c)	_____	_____
	Name of Company	Type of Coverage
(d)	_____	_____
	Name of Company	Type of Coverage

14. Describe hearing defect in detail: _____

15. Date of onset of defect: _____

16. Prior medical treatment (give names and address of doctors):

17. Intended use of grant and anticipated costs: _____

18. Remarks: _____

Date: _____ Signature of Applicant-Parent/Guardian _____

FULL RELEASE

I/We, _____ and _____

_____ an individual/parents of a minor

hereby grant permission to The Scholarship Trust for the Hearing Impaired, 3755 Lindell Boulevard, St. Louis, Missouri 63108-3476, its Trustees and employees, to take photographs and/or video tapes of said individual/minor child. I/We hereby authorize the exhibition, reproducing, publishing, televising and use of these photographs and/or video tapes for educational, information, and advertising purposes, including, but not by way of limitation, publication in the Travelers Magazine and use of said individual/minor's name and address in conjunction therewith.

In our/my own behalf, and in behalf of _____,

I/We hereby relinquish all right, title and/or interest that _____
I/We may have to such video tapes, finished pictures, negatives, reproductions and copies of the original prints and negatives, and further grant unto The T.P.A. Scholarship Trust for the Hearing Impaired the right to exhibit, assign and transfer in whole or in part, said video tapes, negatives, original prints, and copies, or facsimiles thereof.

This instrument shall be binding upon the undersigned, and the undersigned's heirs, executors, administrators, successors and assigns.

Witness my/our hand at _____ this _____ day of _____, 20_____.

Signature of Individual/Parent

Witness

Signature

Witness

Signature

Witness

Signature

NOTE

Please include Photo of Applicant with this form.

MEDICAL AUTHORIZATION

Date _____

TO WHOM IT MAY CONCERN:

I hereby request and authorize you to furnish T.P.A. Scholarship Trust for the Hearing Impaired, or its representative, any and all information you may have concerning _____ with respect to any hearing defect, illness or injury, medical history, consultation, prescription or treatment, including x-ray plates and copies of all hospital or medical records.

Witness to Signature: _____

Signed: _____
Address: _____

A photostatic copy of this authorization shall be considered as effective and valid as the original.

T.P.A. Scholarship Trust for the Hearing Impaired
3755 Lindell Boulevard, St. Louis, Missouri 63108-3476

MEDICAL CERTIFICATION

1. Name of Patient: _____
 2. Diagnosis of Hearing Defect: _____
 - 2a. Degree of Loss: _____ Right Db. _____ Left Db.
 3. Date of Diagnosis: _____
 4. Medical Recommendation for Future Treatment: _____

 5. Estimated Cost of Recommended Treatment: \$ _____
Mechanical or Electronic Devices: \$ _____
 6. Prognosis for Cure or Improvement with Treatment: _____

 7. To the best of your knowledge, is patient able to supply costs of recommended future treatment?
Yes: _____ No: _____
 8. If medical treatment and/or mechanical or electronic aids will not benefit patient, is specialized education or training recommended? Yes: _____ No: _____
If yes, describe type and place of education or training: _____

 9. Remarks: _____

- Date: _____

Signature of Physician/Audiologist

Street Address

City State Zip

UnitedHealthcare Children's Foundation

The UnitedHealthcare Children's Foundation is a 501(c)(3) non-profit charity dedicated to facilitating access to medical-related services that have the potential to significantly enhance either the clinical condition or the quality of life of the child and that are not fully covered by the available commercial health benefit plan. This "support" is in the form of a medical grant to be used for medical services not covered or not completely covered by commercial health benefit plans.

In evaluating applications, the Regional Board will consider applications based on the following criteria:

1. The following items are excluded from grant consideration: dental or orthodontic treatment unrelated to a serious medical condition, biomedical consultations, chelation therapy (this exclusion does not apply for a primary medical diagnosis of lead toxicity confirmed by blood lead levels), educational tutoring, heavy metal toxicity testing, herbal testing, home improvement/modifications, hyperbaric oxygen treatment, service dogs and other pets (does not apply to animals who support the visually impaired), camps, therapies of feeding, listening, vision, cognitive, neuro-feedback and social skills.
2. The applicant must be 16 years old or younger and live in the United States and receive and pay for care/items in the United States.
3. The applicant must be covered by a commercial health benefit plan and limits for the requested service are either exceeded, or no coverage is available and/or the copayments are a serious financial burden on the family. The UnitedHealthcare Children's Foundation requires a commercial health benefit plan. A commercial health benefit plan is defined below:

Included

- * Your commercial health benefit plan is offered through:
 - * Your commercial (private) employer. Example: most grant applicants whose parent works for a commercial entity will have this type of health insurance.
 - * Your health benefit plan is offered through a commercial health plan that you individually purchased. Example: small business owners, sole-proprietors, etc.
 - * Your health benefit plan is offered through your employment with a town, city, state or federal government. Example: teachers, police officers, active duty or civilian military duty, etc.

Excluded

- * Medicaid, Medicare, SCHIP (which may be called various names by each state), HIS or other state or federally subsidized health insurance programs given to those without insurance or with low incomes.

4. The potential of the intervention to significantly enhance either the clinical condition or the quality of life for the child, the financial status of the family and the severity of the child's illness. If a grant is approved, services must be provided by a trained, and if appropriate, licensed professional.

5. Financial need of the child's family will be evaluated and documented through information provided on the application and by submission of a photocopy of the most recently filed Federal tax return (Internal Revenue Service 1040, 1040-A, or 1040-EZ). The following scale will be used to determine financial eligibility:

Your Family Size As reported on your IRS 1040	Adjusted Gross Income As reported on your IRS 1040
2	\$50,000 or less
3	\$75,000 or less
4	\$100,000 or less

5 or more

\$125,000 or less

6. Awards will NOT be granted to individuals in families whose Adjusted Gross Income (AGI) exceeds the scale.
7. Other financial resources to meet the health care need are not available.
8. The amount awarded to an individual within a 12-month period is limited to either \$5,000 or 85% of the fund balance, whichever amount is less. Awards to any one individual are limited to a lifetime maximum of \$10,000.
9. Grant recipients who are awarded less than \$5,000 may re-apply for another grant once the current grant funds have been completely exhausted. The 12-month \$5,000 limit (or 85% of the fund balance) and \$10,000 lifetime maximum limits apply.
10. An application must be submitted prior to the child's 17th birthday.
11. The health care professional is to be paid directly; exceptions can be made to reimburse the family if adequate documentation is submitted showing the health care professional has been paid.
12. Applications are to be reviewed by a health care professional appointed by the Foundation to determine the medical appropriateness of the treatment.
13. Grant awards are retroactive to sixty days prior to the date of application and have an expiration date of approximately one year, unless the funds are exhausted prior to the expiration date. The grant will NOT cover any medical costs outside this date range.
14. Applicants who are not approved by the Regional Board must wait a period of twelve months before re-applying, unless the medical condition and requested items have significantly changed from the original request.

In order to apply for your child, the child must live with you 51% or more and be listed as a dependent on your most recently filed IRS 1040. If the child is not listed on your most recently filed IRS 1040, then we need a copy of both your most recently filed IRS 1040 and the most recently filed IRS 1040 on which the child is listed as a dependent.

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