APPLICATION FOR HEARING AIDS

INFORMATION

If you do not have a printer, please use the on-line application instead.

- If you need help finding a clinical audiologist or paying for clinical audiology services, please contact Hear in the Fox Cities directly. Our email is hear@hearinthefoxcities.org
- Having insurance is not exclusionary; Hear in the Fox Cities understands that high deductibles and copays may still make the purchase of hearing aids difficult without assistance.
- Hearing aid repairs and earmolds costs may be covered, separate from new hearing aid orders, see the mini-application online for costs under $400.
- Hear in the Fox Cities uses a sliding fee scale (pages 4-5) which outlines general financial considerations.
- Applications will be reviewed by the board in a timely manner and the applicant contacted with a decision.

HEAR in the Fox Cities will provide funding for hearing aids as long as the funds are available. We reserve the right to change eligibility at any time without written notification.

INSTRUCTIONS: Applications can be mailed, faxed, or emailed.

- Mail: 1948 Palisades Drive, Appleton WI, 54915
- Fax: 920-882-3715 (Attn: Hear in the Fox Cities)
- Email: hear@hearinthefoxcities.org

Please include the following upon submission to Hear in the Fox Cities:

- Parent/Guardian application portion (pages 2-3)
- Clinical Audiologist application portion (pages 6-7)
- Audiogram within 6 months
- Quote (see page 7)

THIS APPLICATION MUST BE SUBMITTED BEFORE THE HEARING AIDS ARE FIT!!!!

TO BE COMPLETED BY THE PARENT/GUARDIAN

Patient Information

Patient Name: _____ Gender:_____ DOB: _____

Parent/Guardian Information:

Name: _____ Address: _____

Relationship to patient: _____ City/State/Zip: _____

County: _____

Insured Person:_____ Insured Date of Birth: _____

Phone: _____ Email:_____

Preferred method of contact: _____

Does the patient have medical insurance? YES NO

Is there hearing aid coverage? YES NO

If yes, please list coverage:

_____

_____

Insurance Information – Primary (found on insurance card):

Insurance Company Name: _____

ID #:_____Group #: _____

Employer (of Insured):

_____

Insurance Information – Secondary (if applicable)

Insurance Company Name: _____

ID #:_____Group #: _____

Employer (of Insured):

_____

By signing below, I am giving permission to release records relating to Audiology and other records related to my hearing and to contact the applicant's health insurance about eligibility notices and information on coverage for

hearing aids.

Patient Name *Parent/Legal Guardian Name* *Signature* *Date*

Please document financial hardship by providing income and expenses: (ie medical bills, loss of income, mortgage/rent, childcare etc) and/or other extenuating circumstances. Add additional pages and documentation as needed**. Also please email us copy of Paystub or W2 from parents or guardian.**

VIDEO AND PHOTOGRAPHY CONSENT

Hear in the Fox Cities recognizes the need to ensure the welfare and safety of all young people receiving hearing aid donations. We would be grateful if you would give us permission to take photos or videos of your child and use these in our printed and online publicity.

I grant full rights to use the images resulting from the photography/video filming, and any reproductions or adaptations of the images for fundraising, publicity, or other purposes to help achieve the group's aims.

This might include, but is not limited to, the right to use them in printed and online publicity, social media, and press releases.

☐ I give Hear in the Fox Cities permission to take photographs and/or or video of my child.

Patient Name *Parent/Legal Guardian Name* *Signature* *Date*

☐ I do not give Hear in the Fox Cities permission to take photographs and/or or video of my child.

Patient Name *Parent/Legal Guardian Name* *Signature* *Date*

HEAR IN THE FOX CITIES SLIDING SCALE FEE

This is our policy to provide discount services to those in need. It is designed to provide free or discounted care to those who have no means, or limited means, to pay for hearing care services such as hearing aids, hearing exams, ear molds and/or repairs.

Hear in the Fox Cities will offer a Sliding Scale Fee Scale to all who are unable to pay for the hearing care services. Eligibility will be based on a person's ability to pay and will not discriminate on the basis of an individual's race, color, sex, national origin, citizenship, disability, religion, age, sexual orientation, or gender identity. The Federal Poverty Guidelines are used in creating and annually updating the sliding fee schedule to determine eligibility.

The following guidelines are to be followed in providing the Sliding Fee Scale

1. Notification of the Sliding Fee Scale will be listed on the hearing aid application.
2. The Sliding Fee Scale determination will be reviewed be the Hear in the Fox Cities board. Confidentiality will be respected for all who complete the application.
3. Those with incomes at or below 200% (x2) of the federal poverty level (FLP) according to the latest Federal Poverty Guidelines will receive a full 100% discount. Those with incomes above 200% FLP, but at or below 400%, will be charged a percentage fee of patient/family responsibility. The minimal fee is 10%. Everyone's sliding scale fee will vary. Families with extenuating circumstances, such as recent unemployment, extraordinarily high medical bills, or other bills will be considered. Hear in the Fox Cities will take into consideration family circumstances. Those with incomes above 400% FPL with extenuating circumstances are still encouraged to apply.
4. The responsible party must provide one month of household income (ie. earnings, unemployment, compensation, workers compensation, Social Security, alimony, child support ect.) You may also include in writing any extenuating circumstances or financial hardship as you see fit.
5. The Sliding Fee Scale program determination will be provided to the applicant and will include the amount the patient's family is responsible for or if applicable, the reason for denial. Applicants will be notified of the board's decision including any financial responsibility, within a 2–3-week timeframe.

Hear in the Fox Cities wants families to qualify for this program. Every child or young adult under the age of 21 in our community who needs hearing aids, ear molds, a hearing exam, or hearing aid repairs is encouraged to apply.

Federal Poverty Level (FPL) Guidelines

Effective January 1st 2025

Household Size	% FPL	0%	100%	138%	150%	200%	213%	250%	266%	300%	322%	400%*
	1	$0	$15,060	$21,597	$22,590	$30,120	$33,335	$37,650	$41,629	$45,180	$50,393	$60,240
	2	$0	$20,440	$29,187	$30,660	$40,880	$45,050	$51,100	$56,259	$61,320	$68,103	$81,760
	3	$0	$25,820	$36,777	$38,730	$51,640	$56,765	$64,550	$70,889	$77,460	$85,813	$103,280
	4	$0	$31,200	$44,367	$46,800	$62,400	$68,480	$78,000	$85,519	$93,600	$103,523	$124,800
	5	$0	$36,580	$51,957	$54,870	$73,160	$80,195	$91,450	$100,149	$109,740	$121,233	$146,320
	6	$0	$41,960	$59,547	$62,940	$83,920	$91,910	$104,900	$114,779	$125,880	$138,943	$167,840
	7	$0	$47,340	$67,137	$71,010	$94,680	$103,625	$118,350	$129,409	$142,020	$156,653	$189,360
	8	$0	$52,720	$74,727	$79,080	$105,440	$115,340	$131,800	$144,039	$158,160	$174,363	$210,880
	add'l, add	$0	$5,380	$7,590	$8,070	$10,760	$11,715	$13,450	$14,630	$16,140	$17,710	$21,520

COMPLETED BY THE AUDIOLOGIST

Audiologist Information:

Provider Name: _____

Practice/Facility: _____

Address: _____

Phone: _____

Email: _____

Preferred method of contact: _____

Patient Information

Patient Name: _____ DOB: _____

Audiologic Information:	**Left Ear**	**Right Ear**
Type of Hearing Loss		
Degree of Hearing Loss		

Previous Hearing Aid user? YES NO

If yes, previous hearing aid(s): _____

Currently wearing hearing aids? YES NO

If yes, list the following:

Manufacturer & Model: _____

Original Fit Date: _____

Warranty Repair Expiration Date:_____

Recommended Hearing Aids

Manufacturer & Model: _____

Ear: LEFT RIGHT BOTH

Additional recommendations/comments:

_____

_____

_____

Upon acceptance as the hearing aid provider for your patient, you agree to the following terms:

1. Recommend and fit the optimum amplification that is most appropriate for the child seeking funding.
2. Schedule the fitting appointment next available, not to exceed 1 month, to expedite the fitting of hearing aid(s).
3. Fit the patient using best practices including, but not limited to, verification and validation with Real Ear measurements.
4. Provide explanation to the patient's parent(s) and/or guardians the benefits of hearing loops and telecoils.
5. Return the hearing aid(s) purchased by Hear in the Fox Cities if the patient no longer needs the devices or the patient is not fit.
6. Extend all applicable hearing aid manufacturer warranties, including loss and damage warranties, to the patient. Loss and damage deductibles, office visits/service charges after 1 year of service, hearing aid parts outside of manufacturer warranty, and diagnostic services may apply.
7. Comply with all provisions of federal and state laws and regulations relating to the dispensing of hearing aids.

HEARING AID QUOTE & PAYMENT

If billing the insurance company, please provide an estimated itemized invoice. Please include product, insurance discount, estimated insurance payment, and estimated patient responsibility.

If no insurance, then upload an itemized unbundled quote which projects the total cost of audiology services and product.

Hear in the Fox Cities fitting dispensing fee is $600 per ear. Dispensing fee includes 1 year of in-house services rendered including, but not limited to, hearing aid programming, hearing aid clean and checks, earmold services, ect.

If loss & damage deductibles, office visits, or out of warranty repairs are prohibitively expensive patients/audiologists are encouraged to reapply.

*Example Quote: Hearing aid invoice cost including shipping, earmold(s), dispensing fee ($600 monaural, $1200 binaural/BiCROS).

By printing and signing below, I affirm that the information contained in this application is current and complete and I agree to the terms listed above.

Audiologist Name (Print) *Audiologist Signature* *Date*