



# HEAR NOW Program

## APPLICATION



Starkey  
**Hearing**  
Foundation

So the World May Hear



So the World May Hear

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

**Every applicant is asked to call HEAR NOW to discuss eligibility.**

**The application/processing fee is non-refundable and will not be returned under any circumstance.**

The Starkey Hearing Foundation  
HEAR NOW Program  
6700 Washington Avenue South, Eden Prairie, MN 55344

**Call HEAR NOW at 1-800-648-4327 to discuss your eligibility.**

**HOW TO COMPLETE THE PROCESS**

1. Review the **Information to Consider Before Completing the HEAR NOW Application** below.
2. Find a hearing health care professional. The client is responsible for finding a hearing health care professional willing to work with them and the HEAR NOW Program. **HEAR NOW does not provide a list of hearing health care professionals or make referrals to practitioners.** Check the listings in your local phone book under “Audiologists” and/or “Hearing Aids” and call to ask if they are a HEAR NOW provider. If they are a provider, ask if they can take you on as a new client.

**The client is responsible for the cost of the evaluation/assessment AND the non-refundable processing fee to HEAR NOW.** Once the aids are provided, the client is responsible for the purchase of batteries and extended warranty coverage for the aids.

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

The Starkey Hearing Foundation HEAR NOW Program  
6700 Washington Avenue South  
Eden Prairie, MN 55344-3405

Applications are processed as they are received. **Once you mail your application, please wait at least 6 weeks before you call for a status check.**

**INFORMATION TO CONSIDER BEFORE COMPLETING THE HEAR NOW APPLICATION**

1. **Income Guidelines:** For 48 contiguous states and D.C. ONLY. To obtain guidelines for Alaska and Hawaii, please call 800-648-4327. **All income figures are NET. NET means the amount received by all those in the household.**

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

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

2. **Application and Order Processing Fee:** \$100 for one (1) aid **OR** \$200 for two (2) aids.
3. **In determining eligibility, HEAR NOW considers the following:**
  - a. **Household Size** (Household is defined as the number of people financially 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
    - Child Support
    - Welfare
    - Work Pension
    - Black Lung Payments
    - VA Pension
    - Public Assistance
    - AFDC
    - Wages
    - Interest from Stocks, IRAs, 401(k)s
    - Alimony
    - Disability
    - Old Age Pension
  - c. **Assets**
    - Checking
    - Annuities
    - Life Insurance
    - CDs
    - Burial Accounts
    - Money Market Accounts
    - IRA/401(k)
    - Savings
    - Stocks/Bonds

**FINAL CHECKLIST**

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

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

- \_\_\_\_\_ Complete pages 4, 5, and 6 –signature required on page 6
- \_\_\_\_\_ Provide proof of income from all sources (NET income for current year)
- \_\_\_\_\_ Send copies of all pages of bank statements (all accounts) for the most recent 9 months
- \_\_\_\_\_ Find a hearing health care provider willing to work with HEAR NOW
- \_\_\_\_\_ Submit Client Data Sheet (page 9) completed and signed by hearing health care provider
- \_\_\_\_\_ Send current audiogram (less than 9 months old) obtained from the hearing health care provider
- \_\_\_\_\_ Complete medical clearance (Page 10) release (signed by primary physician) or waiver (signed by the client)
- \_\_\_\_\_ Send processing fee of \$100 per hearing aid requested
- This should be in the form of a MONEY ORDER made out to **STARKEY HEARING FOUNDATION**
- The processing fee is a **NON-REFUNDABLE fee**
- \_\_\_\_\_ Provide the most recent copy of all credit card statements you have
- \_\_\_\_\_ Submit most recent statement for all CDs, Money Market Accounts, Burial Accounts, IRAs, 401Ks, Annuities, Stocks and/or Bonds you hold
- \_\_\_\_\_ Send copy of subsidized housing approval notice (if applicable)
- \_\_\_\_\_ Send Medicaid identification form (if you are a Medicaid recipient)

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

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

**Mail all these items at the same time to:**

The Starkey Hearing Foundation  
 HEAR NOW Program  
 6700 Washington Avenue South, Eden Prairie, MN 55344

**HEAR NOW Program - Application for Hearing Aid Assistance**

**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 financially dependent on each other)

Mailing Address:

Street \_\_\_\_\_ Apt. # \_\_\_\_\_

City \_\_\_\_\_ County \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_

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

Person, if other than applicant, completing 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.)

**SOURCE:** \_\_\_\_\_ **AMOUNT:** \_\_\_\_\_

Applicant:

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

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

Spouse/Other:

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

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

**HEAR NOW Program - Application for Hearing Aid Assistance**

**ADDITIONAL INFORMATION:**

Applicant Name: \_\_\_\_\_

**ANSWER ALL QUESTIONS.** Unanswered questions will delay the process.

<b>Do you currently have:</b>	<b>Yes</b>	<b>No</b>	
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 the 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	If yes, provide copy of Medicaid Identification Form

**All applicants are asked to call Hear Now to discuss eligibility for the program. Call 800-648-4327.**

**HEAR NOW Program - Application for Hearing Aid Assistance**

**HOUSEHOLD INFORMATION:**

**Household is defined as all those who are financially dependent on each other.**

Number in Household: \_\_\_\_\_

List names of individuals in household who are financially dependent on each other (i.e., If Minor, list Parent(s); list Dependent(s); list Spouse; list Relative; list Friend, etc.).

<b>Name</b>	<b>Age of Person</b>
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

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 non-refundable application/processing fee will not be returned to me under any circumstance.**

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.



**HEAR NOW Program - Application for Hearing Aid Assistance****Page 8-8****So the World May Hear**

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 (page 9). 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 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 the hearing aids and earmolds when BTE aids are chosen. The hearing aids may be ITE, ITC, BTE, Body and Bone-Conduction type instruments. **CICs are not on the menu of the program.** All instruments provided through the program come with a one-year warranty for repair. It is strongly recommended that extended warranty coverage be purchased through the practitioner's office. If you have questions regarding aids and options, please call HEAR NOW at the number below.

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 re-applying for new hearing instruments.

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

**HEAR NOW Program - Application for Hearing Aid Assistance**

**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

Why? \_\_\_\_\_

Circle your choice of style (**CICs are not an option**):

Custom BTE BODY Bone Conduction # of earmolds (if using BTEs) \_\_\_\_\_

Color of casing (check one):  Beige  Brown  Dark Brown  Gray  Pink Other: \_\_\_\_\_

Suggested Starkey BTE Aid: \_\_\_\_\_

Technology Requested: (check one)  Programmable Digital  Non-Programmable Digital

If you are fitting digital BTEs, do you need any of the following? Please check your needs:  Software  Cables  Boots

**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: \_\_\_\_\_

**HEAR NOW Program - Application for Hearing Aid Assistance**

**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: \_\_\_\_\_



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