



HEAR for Kids® is a program for children who have been identified as needing audiology assessment as a result of a hearing screening. HEAR for Kids® is made possible by a grant from St. Luke's Health Initiatives and private donations.

Parent/Guardian Please Complete this Section

Child's Name: _____ Date of Birth: _____

Home Address: _____

Person Responsible for the child: _____

Relationship to Child: Mother Father Guardian Phone Number: _____ - _____ - _____

Is child eligible for free or reduced lunch program? Yes No Unknown

(If unknown or under age 3, fill out Income and Expense portions of the form)

Income

Total Household income for the past 12 months: \$ _____

Include: Wages/Salary, Pension, Social Security, Child Support and any other income.

Expenses

Number of family members living in your home _____

Total Allowed Deductions for the past 12 months: \$ _____

Include: Total medical/dental not paid for by health insurance or third party, Annual rent or mortgage payment, Annual payments for primary vehicle, Dependent Care. For dependant care, use the following calculations:

Number of children in childcare _____ x \$200 x number of months _____ = _____

Number of incapacitated adults receiving care _____ x \$100 x number of months _____ = _____

Parent responsibility

If your child is eligible and funding is available, you will receive a \$50 voucher to be used as payment for one office visit. The EAR Foundation of Arizona will *not* accept financial responsibility for any additional tests, treatment or office visits.

By signing this form you agree to release information to The EAR Foundation of Arizona, HEAR for Kids® Program. Information specific to your child, and his/her hearing loss, may be shared with other medical, audiology or early intervention professionals or agencies. Information that doesn't specifically identify your child may be published, reviewed for utilization, quality assurance or used to pursue funding for the program.

Parent or Guardian: _____ Date _____

HEAR for Kids®-Audiology Voucher Request

Audiologist/Nurse/School Health Staff Please Complete this Section

1. Specify which Voucher is being requested:

- Audiology Assessment Unsedated ABR/BAER Sedated ABR/BAER

2. If the child is eligible or enrolled in any of the following, that will provide the services, they will **not** be eligible for this program:

- AHCCCS Yes No KidsCare Yes No
 Indian Health Services Yes No Other Health Insurance Yes No

3. Determine eligibility by subtracting amount in the **Expenses** section from the amount in the **Income** section and reviewing the following chart (current as of 8/07).

Number in Family	Annual Income	Number in Family	Annual Income	Number in Family	Annual Income
1	\$15,315	3	\$25,755	5	\$36,195
2	\$20,535	4	\$30,975	6	\$41,415

For each additional person, add \$5,220

If the family income is at or below the listed amount for the number of family members the child will be eligible. If money is available, a voucher will be faxed to you to be given to the family. Please help the family make an appointment with a provider who will accept the voucher as payment. If the family does not meet the qualifications but there are special circumstances, please call Lylis Olsen at (602) 690-3975.

4. Fax *both* sides of this form to HEAR for Kids® at (602) 296-0425.
 5. If you have questions call Lylis Olsen at (602) 690-3975. or email lylisolsen@msn.com
 6. HEAR for Kids® will fax a voucher to the number listed, usually within 48 hours. Call or email if you do not receive a voucher within 5 days.
 7. When you receive the voucher, give it to the family and assist them (as needed) to make an appointment with a provider who will accept the voucher.

Referring person responsibility:

By submitting this form, I acknowledge that I have verified income and expenses, believe that this family is eligible and that all other resources have been explored. The EAR Foundation of Arizona's HEAR for Kids® Program is the payor of last resort and cannot replace insurance, other public or private programs.

Child's Name: _____ Date of Birth: _____
 Name of Referring Person: _____ Date _____
 School/Agency/Facility _____
 Address: _____ zip code: _____
 Phone Number: ____-____-____ Fax Number: ____-____-____ Email: _____

*Please keep a copy of this application and the proof of income and deductions.
 The EAR Foundation of Arizona may request this documentation to verify eligibility.*