THE EAR FOUNDATION® OF ARIZONA

Support From Vitalyst HEALTH FOUNDATION A CATALYST FOR COMMUNITY HEALTH

HEAR for Kids

Parent/Guardian Please Complete this Section

Child's Name: _____ Date of Birth: _____

Home Address: _____Zip code:_____

Person Responsible for child: _____Phone Number: _____-_____-_____

Can we contact you via email? ☐ yes ☐ no email address: _____

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 dependent care, use the following calculations:

Number of children in childcare_____ x $200 x number of months_____=_____

Number of incapacitated adults receiving care_____x$100x number of months_____=_____

Parent responsibility

If your child is eligible and funding is available, you will receive a 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 Eval. □ Unsedated ABR/ASSR □ Sedated ABR/ASSR □ CI Programming
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	Enrolled 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 06/16).

Number in Family	*Annual Income*	*Number in Family*	*Annual Income*	*Number in Family*	*Annual Income*
1	*$17,655*	3	*$30,135*	5	*$42,615*
2	*$23,895*	4	*$36,375*	6	*$48,855*

For each additional person, add $6,240

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. 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 you can call Lylis Olsen at (602) 753-5273 or email HEARforKids@earfoundationaz.com
6. HEAR for Kids will fax a voucher to the number listed. Call or email if you do not receive a voucher within 1 week.
7. When you receive the voucher, give it to the family and assist them (as needed) to make an appointment with an appropriate provider.

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'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