THE EAR FOUNDATION® OF ARIZONA

Support From Vitalyst HEALTH FOUNDATION A CATALYST FOR COMMUNITY HEALTH

HEAR for Kids

Padre/Audiólogo/Enfermera/Personal de Salud Escolar por favor llene esta sección

Nombre del(a) Niño(a): _____ Fecha de Nacimiento: _____

Dirección: _____

Persona Responsable por el(la) niño(a): _____

Parentesco con el(la) niño(a): □ Madre □ Padre □ Tutor Teléfono: _____-_____-_____

Ingresos

Total de ingresos de la casa en los últimos 12 meses: $_____

Incluya:Sueldo/salario, Pensión, Seguro Social, Manutención y cualquier otro ingreso.

Gastos

Total de Deducciones Permitidas en los últimos 12 meses: $_____

Incluya: Total de gastos médicos/dentales no cubiertos por la aseguranza o tercera instancia, renta anual o pago de hipoteca, pagos anuales por vehículo primario, cuidado de dependientes. Para cuidado de dependientes, use los siguientes cálculos:

Número de niños en childcare_____ x $200 x número de meses_____=_____

Número de adultos incapacitados que reciben cuidado_____x $100 x número de meses_____=_____

Responsabilidad de los padres

Si su niño es elegible, y hay fondos disponibles, usted recibirá un volante para ser usado como pago por una consulta. The EAR Foundation of Arizona no aceptará responsabilidad financiera por ningún examen adicional, tratamiento o consultas.

Al firmar esta forma, yo estoy de acuerdo en dar información a The EAR Foundation of Arizona HEAR for Kids® Program que se va usar para determinar elegibilidad, certeza de calidad, y revisión de uso.

Padre o Tutor:_____ Fecha_____

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.