SPIRIT'S HEART

Resource Application

SPIRIT'S HEART

Dear applicant,
Spirit's Heart is dedicated to equip the hard-of-hearing/deaf families with the necessary resources to help them to communicate with one another, to become independent by having deaf accessible products within the home.

If you have been diagnosed with hearing loss and are seeking assistance in the form of Hearing Aid Batteries, Alarm Clock, Flash Doorbell or Closed Caption phones,parent/guardian or homeowner must complete this application and supply the necessary documents in order to be considered.

Please note that application evaluation does not begin until all documents are completed and turned in. Once received, the approval process can take several weeks. You will be notified via email and official letter on the status of your application.

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Eligibility requirements

- Medically diagnosed with hearing loss
- Must prove financial hardship as determined below:

POSSIBLE SOURCES OF INCOME:

- Social Security and SSI
- Public Assistance
- VA Pension
- Child Support
- AFDC
- Old-Age Pension
- Disability
- Alimony
- Welfare
- Work Pension
- Interest from Stock, IRAs, 401 (k)s
- Black Lung Payments

ASSETS (include but not restricted to):

- Savings
- Checking
- Money Market Accounts
- Annuities
- IRA/401(k)
- Reverse Mortgage
- CDs
- Home Equity Loan
- Stocks/Bonds
- Burial Accounts
- Property

General Information

_____
Date:

_____
Applicant First name Applicant Last name

_____
Date of Birth Age

_____
Mailing Address

_____
Street Apt#

_____
City State Zip

_____
Name of Parent/Guardian (Full Name)

_____
Phone Cell Email

Ethnicity:

- ❑ African American
- ❑ Native American
- ❑ Asian American
- ❑ White (not of Hispanic origin)
- ❑ Black (not of Hispanic origin)
- ❑ Latino/Hispanic
- ❑ Hawaiian/Pacific Islander
- ❑ Other_____

Name of person other than applicant, completing this form

_____
First Name

_____
Last Name

_____
Relationship to applicant

_____
Email

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Audiologist Information

_____
Audiologist's Name

_____
Audiologist's Email

_____
Audiologist's Phone

_____
Audiologist's Practice Name

Please indicate what you are applying for

☐ Hearing Aid Batteries ☐ Alarm clock ☐ Flash Doorbell ☐ Closed Caption phone ☐ Other

NOTE: In most circumstances, Spirits Heart can only fund one resource at the time of application, if chosen. If additional services are needed, indicate so in the message field at the bottom of the application.

Amount requested_____

Primary care physician/pediatrician _____

Doctor's name: _____

Doctor's email: _____

Doctor's phone:_____

Doctor's office/clinic: _____

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Approved funds will be distributed directly to the service provider.

Do you currently wear hearing aids?
❑ No ❑ Yes

If yes, indicate below:

Brand

Model

Date received

Do you currently use an FM system? ❑ No ❑ Yes
Do you own it? ❑ No ❑ Yes
If yes, indicate below:

Brand

Model

Date received

Are you participating in speech therapy?
❑ No ❑ Yes
❑ Private
❑ School System

How long have you received speech therapy?

How long were your sessions for speech therapy?

Are you participating in ASL lessons?
❑ No ❑ Yes
❑ Private
❑ School System

How long have you received lessons?

How long were your sessions for ASL lessons?

Applicant's Name of school _____
❑ Public ❑ Private

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HOUSEHOLD AND FINANCIAL INFORMATION

Information is for parents/guardians of applicant.

# of Dependents: _____ Annual Household Income (NET): _____

List all household members

	First Name	Last Name	Relation to applicant	Date of birth
1				
2				
3				
4				
5				
6				
7				
8				

Additional members can be added in the comments section at the end of the application or attached in a separate document.

If selected, you will be asked to show proof of income.

List all sources of income: *(salary, child support, alimony, social security, etc.)*

Parent/Guardian:

A. Source of income _____
Amount _____ $month.

B. Source of income _____
Amount _____ $month.

C. Source of income _____
Amount _____ $month.

Other Parent/Guardian:

A. Source of income _____
Amount _____ $month.

B. Source of income _____
Amount _____ $month.

C. Source of income _____
Amount _____ $month.

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All information must be provided to receive assistance

HOUSEHOLD INCOME	Amount per month	HOUSEHOLD EXPENSE	Amount per month
Net Employment		Mortgage/rent/home insurance	
Unemployment income		Electricity	
Child Support		Gas	
Social Security		Water/Sewer	
Food Stamps		Phone (home/cell/internet)	
Savings		Cable (TV subscriptions)	
Housing Assistance		Health/medical bills & prescriptions	
Other income		Car payment/insurance	
		Childcare	
		Average food expense	
		Other expenses	
TOTAL MONTHLY INCOME		**TOTAL MONTHLY EXPENSE**	

Please attach all current income and expense documents.

Please attach a copy of the first 10 pages of your most recent tax return. If you do not file taxes and receive government benefits, submit a copy of your award statement of these benefits.

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Do you currently have:

Checking: ❑ No ❑ Yes
(if yes, provide a copy of the last 6 months of current bank statements.

Savings: ❑ No ❑ Yes
(if yes, provide a copy of the last 6 months of current bank statements.

CD(s): ❑ No ❑ Yes
(if yes, provide copy of most recent statement.)

Stocks/Bonds: ❑ No ❑ Yes
(if yes, provide copy of most recent statement.)

Annuity: ❑ No ❑ Yes
(if yes, provide copy of most recent statement.)

IRA/401(k): ❑ No ❑ Yes
(if yes, provide copy of most recent statement.)

Money Market Account: ❑ No ❑ Yes
(if yes, provide copy of most recent statement.)

Burial Account: ❑ No ❑ Yes
(if yes, provide copy of most recent statement.)

Do you own property: ❑ No ❑ Yes

Additional information:

Are you a Medicaid recipient: ❑ No ❑ Yes

What is your current health insurance coverage?

_____

Does your health insurance cover hearing aids?

❑ Don't know
❑ No
❑ Yes

If yes, what benefit? _____

_____
Group #:

_____
Member ID # (applicant):

_____
Name of policy holder:

_____
Date of Birth of policy holder:

❑ Don't know

HEARING INFORMATION

Please attach audiogram. For any sponsorship to be considered, audiogram must accompany application.

Age when hearing loss was diagnosed: _____

If applicable, age at which applicant was fitted with hearing aid(s): _____

If applicable, age at which applicant received cochlear implant(s): _____

Applicant uses listening and spoken language as the primary mode of communication: ❑ No ❑ Yes

What other method(s) of communication and educational support service(s) are used in daily communications and educational settings? **Check all that apply.**

❑ Lip Reading
❑ Cued Speech
❑ Note Taker
❑ Communication Access Real-time Translation (CART/Captioning)
❑ Oral Interpreter(s)
❑ Sign Language Interpreter(s)
❑ Auditory Listening Device, such as FM System
❑ Sign Language System (ASL, Signed English, Finger Spelling, etc.).

I use sign language with: **Check all that apply.**

❑ Teachers/professors
❑ Friends who are deaf
❑ Friends with typical hearing
❑ Other, please describe:

Why should you be chosen for this program? _____

_____

_____

_____

_____

_____

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Spirit's Heart Program Participation Agreement

I understand that the information I submit to Spirit's Heart concerning the applicant's level of hearing loss, medical history, parent/guardian's annual income, family size, family resources, insurance and all financial information is Subject to verification by Spirit's Heart. I understand that if I knowingly omit or submit false information, I will be Denied consideration.

_____

Applicant's Full Name

_____

Parent/Guardian Signature and Date

Authorization for Use and Disclosure of Information Waiver

I authorize Spirit's Heart to use my and or my child's photo to help bring awareness to other families in need. Images and information will be used for the nonprofit's marketing materials, which includes printed collateral,social media campaigns, radio stations, television, newspapers, newsletters, corporate scrapbook/bulletin and other Media.

_____

Applicant's Full Name

_____

Parent/Guardian Signature and Date

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