sound of Life FOUNDATION

Understand – Communicate – Participate Program

Application 2023

Valid through December 31, 2023

A 501(c)3 Non-Profit Organization

Dear Applicant,

Thank you for contacting the Sound of Life Foundation's Understand – Communicate – Participate Program for hearing aid assistance. Our goal is to provide hearing aids to individuals who meet the criteria and are approved for assistance. This Program is designed to assist those who have **no other resource** available to them. Other options for assistance include; family support, insurance, state Medicaid program, vocational rehabilitation, school district, Veterans Affairs, church groups, state or local programs. ***We are a program of last resort.***

Assistance comes through manufacturer donations, hearing health care providers in your area and donors across the U.S. The hearing healthcare provider is not reimbursed for his/ her time from the Sound of Life Foundation. We deeply appreciate the time, effort and generosity they commit to the Sound of Life Foundation recipients. We trust you will treasure the dedication and commitment from these generous individuals.

If the applicant has family support or funds available in money market accounts, mutual funs 401(k) plans, IRA's, CDs (certificate of deposit), checking/savings accounts, stocks, bonds, T-bill or property, **this program may not be the program for them.** The Sound of Life Foundation considers all possible funding sources when determining eligibility. Only those who fall within the program guidelines for income, assets and hearing loss will be considered for assistance. The current application **processing fee is $350.00.** If an application is denied, the processing fee will be returned.

The hearing healthcare provider will assist in the applicant determining the number of hearing aids needed to help the applicant hear better. Since there is a five-year timeline for reapplying for assistance, the number of hearing aids should be chosen carefully. Once the applicant is approved, the number of hearing aids cannot be changed. Every applicant is asked to call the Sound of Life Foundation to discuss their eligibility for the program. Please call 1-435-574-4744 to speak to a representative.

- The application processing fee will be returned if an applicant is denied.
- Application Materials are reviewed by Sound of Life Foundation staff only.
- When eligibility is determined, financial papers are shredded.
- Names and addresses of applicants are never sold or shared with others.
- **Any outstanding previous balance with the referring clinic must be paid in full/payment arrangements made, prior to being fit with SOLF devices**.

INFORMATION TO CONSIDER BEFORE COMPLETEING THE SOUND OF LIFE FOUNDATION APPLICATION

1. Income Guidelines: All income figures are NET. Net is the amount you actually receive in your check(s) regardless of source.

2019 Income Guidelines

Household Size	Gross Monthly Income	Annual Income
1	$2,010	$24,120
2	$2,706	$32,480
3	$3,403	$40,840
4	$4,100	$49,200
5	$4,796	$57,560

2. **Application and Order Processing Fee:** $350.00.

3. **In determining eligibility, Sound of Life Foundation considers the following**: funds available from all sources, assets and hearing loss.

Household size (household is defined as those living together or dependent of each other)

Net Monthly or Annual Income from all in the household who have income.

Possible sources of income are:

- Social Security
- Public Assistance
- AFDC
- Wages
- Interest from Stock
- SSI
- Alimony
- Disability
- Pension
- IRA's, 401(k)s
- VA Pension
- Welfare
- Black Lung Payments
- Child Support

Assets (include, but are restricted to)

- Checking
- Annuities
- Savings
- Stocks/Bonds
- Money Market Accounts
- IRS/401(k)
- CD's
- Burial Accounts
- Reverse Mortgage
- Home Equity Loan
- Property

Sound of Life Foundation reserves the right to change eligibility criteria without prior written notice.

Application

Information needed to submit with application:

- **Copy of Driver's License or State ID***
- **Copy of the 2 Most recent paystubs (if employed)**
- **Copy Last 3 months bank statements***
- **Copy IRA/Investment Income/401k/ Stocks/ Bonds or other assets (if applicable)**
- **Copy Proof of Residence (utility bill, lease, other)***
- **Proof of Social Security or Disability Income (if applicable)**
- **Proof of Unemployment Income (if applicable)**
- **Proof of government financial assistance or Food Stamps (if applicable)**
- **Letter of Denial of Benefits (Medicaid, Insurance or Financial Aid) if applicable**
- **Letter of Outstanding circumstances or Medical Expenses**
- **Income verification filled out for all of those in household***
- **Hearing test result from Audiologist or Hearing Instrument Specialist within 6 months***
- **Money order or cashiers check for the processing fee ($350.00)***

payable to: Sound of Life Foundation

If the application is denied, the fee will be returned.
Application will not be processed without processing fee. Should you feel that you have extenuating circumstances, please contact our office.

PLEASE DO NOT SEND ORIGINAL DOCUMENTS; THEY WILL NOT BE RETURNED TO YOU.

Mail application and all documents to:

Sound of Life Foundation

180 N Main street, #2378

St. George, UT 84771

Please wait two (2) weeks before making a call to check the status of your application

- Additional information may be needed after initial review of the application
- Sound of Life Foundation reserves the right to change criteria at any time without prior notice
- * **Documents need to be included upon application submission for processing to proceed**

Application

Please print clearly **Date**_____

Personal information

Applicant's Name: First: _____ **Middle:** _____ **Last:** _____

Date of Birth: _____ **Social Security Number:** _____ ☐**Male** ☐**Female Marital**

Status: ☐**Married** ☐**Single** ☐**Divorced** ☐**Widowed** ☐**Separated**

Preferred spoken language: _____

Mailing address: _____

_____

_____

Email address: _____

Cell phone number: _____ **Home phone number:** _____

Primary Care Physician: _____ **Phone number:** _____

Employment status: ☐**Employed** ☐**Retired** ☐**Other**

Current Employer: _____ Phone : _____

How long have you been employed there? _____ (Years/ Months)

Is your work environment very loud or noisy? Y N

Do you currently wear hearing aids? Y N If Yes, how long have you had them? _____

Person, if other than applicant, completing this form. If minor, list parent/guardian's information.

Name: _____ Relationship to Applicant: _____

Phone: _____

Household

Household is defined as all those who live together or are dependent on each other.

Number in Household: _____

List names of individuals (use separate sheet if needed)

Names:	**Age of Person**
Self_____	_____
_____	_____
_____	_____
_____	_____

Income

If the 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.) for all in household.

Applicant's

A. _____ **$** _____ **Month or Year** ***(circle one)***

Source of income

B. _____ **$** _____ **Month or Year** ***(circle one)***

Source of income

Spouse/Other

A. _____ **$** _____ **Month or Year** ***(circle one)***

Source of income

B. _____ **$** _____ **Month or Year** ***(circle one)***

Source of income

If there are additional income earning residents in your household, please list on separate page

CHECK ONE BOX FOR EACH ITEM. Unanswered questions will delay the process

Do you currently have:	Yes	No	
Checking Account	☐	☐	If yes, provide all pages of three (3) months statements
Savings Account	☐	☐	If yes, provide all pages of three (3) months statements
CD(s)	☐	☐	If yes, provide most recent statement
Stocks/Bonds	☐	☐	If yes, provide most recent statement
Annuity	☐	☐	If yes, provide most recent statement
IRS/401k	☐	☐	If yes, provide most recent statement
Money Market Account	☐	☐	If yes, provide most recent statement
Burial Account	☐	☐	If yes, provide most recent statement
Are you a Medicaid Recipient	☐	☐	If yes, provide most recent statement

What health insurance company provides your coverage: _____

Does your health insurance offer a benefit for hearing aids?

☐ **Yes** ☐ **No**

CHECK ONE BOX FOR EACH ITEM. Unanswered questions will delay the processing.

- **Do you have any physical and or diagnosed mental disability?** ☐ Yes ☐ No
- **What is your highest level of education completed?** _____
- **What is your primary language?** _____
- **Do you require an interpreter for medical/wellness visits?** ☐ Yes ☐ No

YES	NO	Do you receive any of the following? Please check Yes or NO
☐	☐	Supplemental Security Income (SSI) or Social Security Disability Income (SSDI)
☐	☐	Medicaid
☐	☐	HEAT (Home Energy Assistance Target Program)
☐	☐	Lifeline (emergency phone service)
☐	☐	Aid to Families with Dependent Children (AFDC)
☐	☐	Emergency Work Program
☐	☐	Food Stamps
☐	☐	Refugee Assistance
☐	☐	Temporary Assistance to Needy Families (TANF)
☐	☐	Work Toward Employment
☐	☐	Federal Public Housing assistance, including Section 8 Housing
☐	☐	National School Lunch Free Lunch Program
☐	☐	General Assistance, (single adults or married couples without children who are unable to work because of a short or long-term disabling condition

Application

The following information is not mandatory, but helpful for our funding efforts

- **What is your primary racial identity?**

☐ African- American ☐ Caucasian

☐ Asian-American ☐ Native Hawaiian/Pacific Islander ☐ Hispanic American

☐ Native-American/Native Alaskan ☐ Asian-Indian ☐ European

☐ Hispanic ☐ Asian other ☐ MultiRacial ☐ Other

Release of information

I understand that the information I submit to Sound of Life Foundation concerning my annual income, family size, family recourses, insurance, medical history and all financial information is subject to verification by Sound of Life Foundation 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.

Applicant's Name: _____Spouse's Name: _____

Date of Birth: _____ Date of Birth: _____

Applicant's Signature_____

Spouse's Signature _____

(If Minor, parent or guardian signature requires.)

If signed by power of attorney (POA), please send a copy of POA. The laws of the state of Utah shall govern the resulting transaction and any claim or dispute arising out of such transaction.

Hearing Care Professional to fill out

Each requested item serves a purpose. This information is used to notify the patient and the practitioner when the application is approved and for shipment of hearing aids and earmolds.

Name of Professional: _____

Name of Practice: _____

Address: _____

Street City State ZIP

Phone : _____ E-mail Address:_____

State Licensure/Registration#: _____

F-AAA_____ BC-HIS_____ HIS _____

Name of Applicant: _____ DOB: _____

Does Pt currently wear devices? YES NO If YES, MAKE _____ MODEL _____

Hearing loss amount Right ear MILD MODERATE SEVERE PROFOUND

Hearing loss amount Left ear MILD MODERATE SEVERE PROFOUND

Style of hearing aid requested for this patient?	BTE	RITE
Number of hearing aids requested for patient?	1	2
If only one hearing aid, which ear?	Right	Left

Hearing Aid Options (Check the hearing aid of your choice)

_____Refurbished **(Premium)** _____ Refurbished **(Advanced)** _____**Bi-Cros**

Receiver Options for RITE

Medium	**Left**	**Right**	**Power**	**Left**	**Right**
Circle	1 2 3 4 5	1 2 3 4 5		1 2 3 4 5	1 2 3 4 5

Dome Size/Type _____

EARMOLDS AND ACCESSORIES ARE NOT INCLUDED

Pt has been denied for hearing aid financing: Yes No

Signature: _____ Date: _____

One of the following MUST be completed and submitted with application

MEDICAL CLEARANCE FOR HEARING AID USE

To be completed and signed by patient's primary care physician

Date: _____

Patient's Name (please print): _____

The patient listed above has been medically examined and may be considered a candidate for hearing aid use.

Physician's Name (please print): _____

Physician Signature: _____

OR

WAIVER OF MEDICAL CLEARANCE FOR HEARING AID USE

To be completed and signed by patient

Date: _____

Patient's Name (please print): _____

I understand that it is in my best interest and recommended by Sound of Life Foundation 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.

Patient Signature: _____

A 501(c)3 Non-Profit Foundation
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