



**aidthesilent**  
Resources Application

# aidthesilent

Dear applicant,

Aid the Silent is dedicated to equip hard-of-hearing/deaf children/teens with the necessary tools and resources to help them find personal success. If you have been diagnosed with hearing loss and are seeking assistance in the form of hearing aids, FM system, speech therapy or ASL lessons, your parent/guardian 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 complete 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.

# Resources Application

Hearing aids, FM system, ASL lessons, speech therapy)

## Eligibility requirements

- Applicants reapplying for assistance cannot do so within 5 years of awarded resources.
- Between the ages of 2 and 18 years old
- Medically diagnosed with bilateral hearing loss with moderate to profound loss
- Maximum annual household income as determined below:

Number of Dependents	Total Household Income (NET)
1	\$22,980
2	\$31,020
3	\$39,060
4	\$47,100
5	\$55,140
6	\$63,180
7	\$71,220
8	\$79,220
Each additional person	\$4,060

## 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

**In determining eligibility, Aid the Silent will consider funds from all sources of income.**

## GENERAL INFORMATION

Date

Applicant's First Name

Applicant's Middle Name

Applicant's Last Name

Date of Birth

Age

Mailing Address

Street

Apt#

City

State

Zip

Name of Parent/Guardian (full name)

Home Phone

Cell Phone

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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*\*Aid the Silent reserves the right to change eligibility criteria.*

## Audiologist Information

\_\_\_\_\_  
Audiologist's Name

\_\_\_\_\_  
Audiologist's Email

\_\_\_\_\_  
Audiologist's Phone

\_\_\_\_\_  
Audiologist's Practice Name

### Please indicate what you are applying for:

- Hearing Aids                       Camp  
(IF APPLYING FOR CAMP,  
PLEASE FILL OUT CAMP  
APPLICATION INSTEAD)
- FM System
- Speech Therapy

ASL Lessons

**NOTE:** In most circumstances, Aid the Silent 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 \_\_\_\_\_

**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

## HOUSEHOLD AND FINANCIAL INFORMATION

Information is for parents/guardians of applicant.

# of Dependents: \_\_\_\_\_ Annual Household Income (NET): \_\_\_\_\_

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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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.

**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

**Aid the Silent Program Participation Agreement**

I understand that the information I submit to Aid the Silent 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 Aid the Silent. I understand that if I knowingly omit or submit false information, I will be denied consideration.

Applicant's Full Name \_\_\_\_\_

Parent/Guardian Signature \_\_\_\_\_ Date \_\_\_\_\_

**Authorization for Use and Disclosure of Information Waiver**

I authorize Aid the Silent to use my child's information and 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 \_\_\_\_\_ Date \_\_\_\_\_

**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? \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

*(Please attach additional documents if necessary).*

Any additional information that should be considered? (Please attach additional documents if necessary). \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

