

HEARING AID APPLICATION

PERSONAL INFORMATION

Please fill out this form in its entirety. Incomplete forms *will not* be considered.

First Name M.I. Last Name Salutation ☐ Mr. ☐ Mrs. ☐ Ms.

SSN - - Birth Date / / Gender ☐ M ☐ F

Marital Status ☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed Primary Phone - -

Email Household Size (numbers only)

Street Address

Zip City State

Is this your primary residence?

☐ Yes ☐ No

Race & Ethnicity

☐ American Indian or Alaskan Native ☐ Asian ☐ Black or African American ☐ Native Hawaiian or Other Pacific Islander ☐ White ☐ Other

☐ Hispanic or Latino ☐ Not Hispanic or Latino

Spouse First Name Spouse M.I. Spouse Last Name Spouse Salutation ☐ Mr. ☐ Mrs. ☐ Ms.

Spouse SSN - - Spouse Birth Date / / Spouse Gender ☐ M ☐ F

FINANCIAL INFORMATION

Did you or your spouse file a federal income tax return last year?

☐ Yes ☐ No

Please enter the **annual amount** received by you and your spouse.

Social Security Benefits

Amount

\$

Spouse Amount

\$

Medicare Part B Premium

Amount

\$

Spouse Amount

\$

Medicare Part D Premium

Amount

\$

Spouse Amount

\$

Medicare Part D Premium

Amount

\$

Spouse Amount

\$

Interest

Amount

\$

Spouse Amount

\$

Dividends

Amount

\$

Spouse Amount

\$

IRA Dividends

Amount

\$

Spouse Amount

\$

Railroad Retirement

Amount

\$

Spouse Amount

\$

Veterans

Amount

\$

Spouse Amount

\$

Pensions

Amount

\$

Spouse Amount

\$

Annuities

Amount

\$

Spouse Amount

\$

Salary

Amount

\$

Spouse Amount

\$

Other Income

Amount

\$

Spouse Amount

\$

HEARING AID APPLICATION

WHO SHOULD WE CONTACT ABOUT THIS APPLICATION?

Contact First Name

Contact Last Name

Contact Phone

 - -

Contact Email Address

PREPARER

If you are filling out this application on someone's behalf, what is your relationship to the applicant?

☐

Spouse

☐

Family Member

☐

Caregiver

☐

Other

Preparer First Name

Preparer Last Name

Preparer Street Address

Preparer Zip

Preparer City

Preparer State

Preparer Phone

 - -

Prepared Date

 / /

REQUIRED DOCUMENTS

Please submit this form with the following documents:

☐

Copy of your Social Security Card

☐

Copy of your state ID

☐

Copy of your previous year's tax return **OR** a copy of your social security benefits letter

☐

Copy of your audiogram/hearing test performed in the last six months

All required documentation must be provided. Incomplete applications *will not* be considered nor processed until all required documentation has been provided to Hough Ear Institute.

AGREEMENTS

Please read and agree to the following before submitting this form:

- ☐ I understand Hough Ear Institute has permission to share my information with its Hearing Aid Program partners and my contact information will be added to Hough Ear Institute's program database.
- ☐ I agree to receive information and correspondence from Hough Ear Institute.

By signing below, I attest that the information provided above is true and accurate to the best of my knowledge.

Printed Name

Date

 / /

Signature