HOUGH EAR INSTITUTE
Hough Aid Program

3400 NW 56th Street, STE A
Oklahoma City, OK 73112-4466
Phone: 405-639-2877

Questions? Want to fill out this document digitally instead?
Email us at: info@houghear.org

HEARING AID APPLICATION

PERSONAL INFORMATION

Please complete all sections to the best of your ability. If something does not apply or you need help, contact us.

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

SSN ***(for identity verification only)*** ___ - ___ - ___ | **Birth Date** ___ / ___ / ___ | **Gender** ☐ M ☐ F

Marital Status ☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed | **Primary Phone** ___ - ___ - ___

Email Address

Street Address

Zip | **City** | **State**

Is this your primary residence? ☐ Yes ☐ No

Are you a U.S. veteran? ☐ Yes ☐ No

How did you hear about this program?

Race & Ethnicity *(Your answer will not impact your eligibility and is purely for demographic information)*

☐ 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

If married or living with a partner, please complete the following:

Partner First Name | **Partner M.I.** | **Partner Last Name** | **Partner Salutation** ☐ Mr. ☐ Mrs. ☐ Ms.

Partner SSN ___ - ___ - ___ | **Partner Birth Date** ___ / ___ / ___ | **Partner Gender** ☐ M ☐ F

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FINANCIAL INFORMATION

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

☐ Yes ☐ No

Please enter the **annual amount** received by you and your partner (if applicable).

Social Security Benefits	Annual Amount $	Partner Annual Amount $
Salary	Annual Amount $	Partner Annual Amount $
Annuities	Annual Amount $	Partner Annual Amount $
Pensions	Annual Amount $	Partner Annual Amount $
Other Income	Annual Amount $	Partner Annual Amount $

Considering the above, what is your household's total annual income, before taxes?

How many people are in your household?

Anything else to note about your income?

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PRIMARY CONTACT FOR THIS APPLICATION

Contact First Name

Contact Last Name

Contact Phone

\- -

Contact Email Address

PERSON HELPING COMPLETE THIS APPLICATION (IF APPLICABLE)

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

☐ Partner ☐ 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 application along with the following documents, or email them to info@houghear.org:
(NOTE: If you do not have all documents right now, submit what you can. We will follow up if anything is missing.)

☐ 1. Copy of your Social Security Card

☐ 2. Copy of a Photo ID (driver's license, state ID)

☐ 3. Financial verification documents for any income on pg. 2
(Such as a tax return if able, or, a copy of your social security benefits letter from ssa.gov)

☐ 4. Copy of your audiogram/hearing test performed in the last six months
NOTE: If you cannot obtain or afford this, you can leave it blank, and we will provide one if you are accepted.

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PARTICIPANT SURVEY

Please fill out this short survey as it helps make this program possible. **Your information will remain anonymous.** Your answers on this survey **will not** affect your eligibility for this program.

1. How often do you experience difficulty in the following situations because of your hearing?

	Never	Rarely	Sometimes	Often	Always
a. Talking one-on-one in a quiet room	☐	☐	☐	☐	☐
b. Having a conversation in a small group (2–4 people)	☐	☐	☐	☐	☐
c. Talking in a larger group or noisy environment (church, restaurant, etc...)	☐	☐	☐	☐	☐
d. Understanding speech on the telephone	☐	☐	☐	☐	☐
e. Following conversations while watching TV, radio, etc	☐	☐	☐	☐	☐

2. How much do the following affect your social life because of hearing loss?

	Not at all	A little	Moderately	Quite a bit	Extremely
a. Avoiding social events or gatherings	☐	☐	☐	☐	☐
b. Difficulty participating in family or community conversations	☐	☐	☐	☐	☐
c. Feeling left out or isolated because you cannot follow conversations	☐	☐	☐	☐	☐
d. Difficulty attending church, community, or family events	☐	☐	☐	☐	☐

3. Please indicate how strongly you agree or disagree with the following statements:

	Strongly Disagree	Disagree	Neither	Agree	Strongly Agree
a. I often feel frustrated when others speak because I cannot hear them clearly.	☐	☐	☐	☐	☐
b. I find that following conversations can be tiring or stressful.	☐	☐	☐	☐	☐
c. I sometimes avoid group conversations because it's too hard to keep up.	☐	☐	☐	☐	☐
d. My hearing loss makes me worry about misunderstandings in important situations (doctor appointments or financial matters).	☐	☐	☐	☐	☐

4. How confident do you feel about doing the following as you are right now?

	Not Confident	Slightly Confident	Moderately Confident	Very Confident	Completely Confident
a. Asking people to speak more slowly or clearly when needed	☐	☐	☐	☐	☐
b. Using tips or strategies (like sitting closer, reducing background noise) to help hear better	☐	☐	☐	☐	☐
c. Managing tasks that require good hearing (e.g., phone calls, scheduling, appointments)	☐	☐	☐	☐	☐
d. Understanding doctors or important information when spoken to	☐	☐	☐	☐	☐

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PARTICIPANT SURVEY (CONTINUED)

5. Before HoughAid, which of the following have been barriers to getting help for your hearing?
Check all that apply.

- ☐ Cost / lack of insurance
- ☐ Transportation or distance to a clinic
- ☐ Not knowing where to get help
- ☐ Concern about stigma or embarrassment
- ☐ Difficulty using the phone or internet to get assistance
- ☐ Other (please specify):

6. How important is it for you to improve your hearing and communication now?

Not Important	Slightly Important	Moderately Important	Very Important	Extremely Important
☐	☐	☐	☐	☐

7. Please tell us, in a few sentences, how your hearing (or hearing loss) affects your daily life now, and/or what you hope will improve through getting hearing aids.
Optional

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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.

HoughAid is designed to support underserved Oklahomans (19 years of age and older) and no other resources for hearing aids, such as insurance, Medicaid, VA, or other state or federal programs. An application process has been put in place and must be completed for those wanting to participate.
If you have no other resources or avenues in which you could receive hearing aids:
Please initial: _____

Hough Ear Institute has established a collaborative partnership with audiologists, who have agreed to provide the following services at no charge to the participant (i.e. will be billed to HoughAid):

1. Diagnostic hearing tests to determine the degree of hearing loss;
2. A follow-on appointment for hearing aid fitting and customized hearing aid education; and
3. Follow-up adjustment appointments within the first year of receiving the hearing aids, as needed.

I understand that any services requested beyond the three listed above are beyond the scope of this program and will be my responsibility.
Please Initial: _____

I understand that I will be receiving free hearing aids that are new or newly refurbished, and my personal information will be shared with Sertoma to verify qualifications of receiving the free hearing aids from their company.
Please initial: _____

I understand that I am confirming that I have no other resources for hearing aids, such as insurance, Medicaid, VA, or other state or federal programs.
Please initial: _____

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

Printed Name

Date / /

Signature