SARANAC LAKE HEALTH ASSOCIATION, INC.
81 MAIN STREET, SUITE 3, SARANAC LAKE, NY 12983
518-891-0910

APPLICATION FOR HEARING AID FINANCIAL ASSISTANCE

To Be Completed by Applicant

Name of Patient: _____ Date of Birth: _____

Name of Applicant if Patient is a Minor: _____ Date of Birth_____

Present Address: _____

Mailing Address (if different): _____

Home Telephone No.: _____ Work Telephone No.: _____ Cell Telephone No.: _____

School District of Residence: _____Referred by: _____

Does Patient Receive Medicaid Assistance, Family Health Plus or have Health Insurance Coverage? ☐ Yes ☐ No
Does It Cover Hearing Aids? _____ If Yes, Please Explain: _____

_____

Total Number of People Living in Applicant's Household _____

Monthly Total Gross Income of All Household Members:		**Monthly Expenses and Disbursements:**	
Wages and Salaries	$_____	Rent/Mortgage payment	$_____
Interest and Dividends	$_____	Real Estate Taxes	$_____
Pension Income, Rental Income, Unemployment,		Utilities, Insurances	$_____
Workers' Compensation	$_____	Loans, Credit Cards	$_____
Child Support, Alimony/Maintenance	$_____	Child Support, Alimony,	
Other Income Including Food Stamps, Social Service		Maintenance, etc.	$_____
Benefits, Social Security, Disability, etc.	$_____	Food	$_____
Other Income **(please explain below)**	$_____	Misc. (please explain below)	$_____
Total Monthly Income	**$ _____**	**Total Monthly Expenses**	**$_____**

Please include 2 different paystubs for each person employed and/or other income verification documentation.

Income Explanation/Comments: _____

_____

_____

Expense and Disbursements Explanation/Comments: _____

_____

_____

Total Cost of Hearing Aid(s) $_____

Less Your Contribution $_____

Amount of Aid Requested $_____

I affirm that the above statements are true and accurate. I consent that the patient audiology records can be released to SLVHA if requested.

_____ _____
Applicant or Patient Signature Date
(Parent or guardian if patient is a minor)

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APPLICATION FOR HEARING AID FINANCIAL ASSISTANCE

To Be Completed by Audiologist

Audiologist Name: _____ Address _____

Patient's Name: _____

Address: _____Home Phone No: _____

_____

Patient's Diagnosis: _____

_____

_____

_____

_____

_____

_____

_____

How many hearing aids does the patient need? _____

Total Retail Cost of hearing aid(s): $_____

Discount, if any, applied by audiologist: - _____

Adjusted Cost of hearing aid(s): $_____

Audiologist Signature: _____ Date _____

FOR OFFICE USE ONLY

Approved by SLHA $_____

Patient Contribution $_____

By: _____ _____
Board or Committee Member Date

By: _____ _____
Board or Committee Member Date

Denied by: _____ _____
Board or Committee Member Date

Denied by: _____ _____
Board or Committee Member Date

Reason for Denial: _____

_____

_____

_____

Notes:_____

_____

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