

## **Roswell Sertoma Hearing or Speech Assistance Request**

Dear Prospective Applicant,

The Roswell Sertoma Club has limited funds and must be considered as a payer of last resort.

Please follow the recommended procedure prior to applying for funding:

- Contact your Health Care Provider and see if they will cover testing and/or hearing aids. Please advise as to the extent of your coverage.
- Child Patient- The state of New Mexico requires individual and group health insurance policies to cover \$2,200 per hearing aid every three years for children under 18 years of age, or under 21 years of age if still attending high school. Coverage includes fitting and dispensing services, including providing ear molds as necessary to maintain optimal fit, provided by and audiologist, a hearing aid dispenser or a physician, licensed in New Mexico.
- Working Age Patient- contact your Vocational Rehab for assistance.
- Veteran-Contact your local VA office for assistance first.

If you have attempted all of these avenues for help and have been denied, please fill out the Roswell Sertoma Club application for financial assistance and send it to us.

Mail the application with Proof of Income to:

- The Roswell Sertoma Club  
P.O. Box 202  
Roswell, New Mexico 88202-0202

**PATIENT INFORMATION**

Name:

Address:

City:

Zip:

**PLEASE PRINT**

Date of Birth:

Age:

Home Phone:

Alternate Phone:

Email:

**PARENT / GUARDIAN / SPOUSE INFORMATION**

Mother / Guardian:

Address:

City:

Zip:

Father / Guardian:

Address:

City:

Zip:

**FINANCIAL INFORMATION OF HOUSEHOLD**

Employer:

Address:

Phone:

Position:

Employer:

Address:

Phone:

Position:

**HOME AND ASSETS OF HOUSEHOLD**

Gross Monthly Income: \$

Checking Account: \$

Savings Account: \$

Gross Monthly Income: \$

Checking Account: \$

Savings Account: \$

(Verification of income must accompany this application (such as IRS Tax Return, pay stubs or income verification from employer).

**OTHER INCOME**

Child Support: \$	Pension: \$
Commissions: \$	Rental Income: \$
Shared Living: \$	Alimony: \$
Disability: \$	Interest: \$
Stocks, Bonds, Annuities: \$	Other: \$

**AUTO(S): YEAR / MAKE / MODEL**

**ALLOWABLE FINANCIAL LIABILITIES / MONTHLY EXPENSES**

	<u>MONTHLY</u>	<u>BALANCE</u>
House / Apartment	\$	\$
Car / Transportation	\$	\$
Medical / Dental	\$	\$
Loans (non-credit card)	\$	\$
Utilities	\$	
Child Care	\$	
Insurances	\$	
Groceries	\$	
<b>TOTAL MONTHLY EXPENSES</b>	\$	<b>BALANCE TOTAL \$</b>

1. Are you receiving Medicaid benefits? Yes\_\_\_\_ No\_\_\_\_  
 If yes, have you applied for hearing aids through Medicaid? Yes\_\_\_\_ No\_\_\_\_  
 If yes, provide status of application. \_\_\_\_\_  
 If no, reason why not? \_\_\_\_\_
  
2. Are other resources (family, friends, church, community, etc.) available to request assistance to purchase either one or both hearing aids? Yes\_\_\_\_ No \_\_\_\_
  
3. Have you already requested assistance from other resources? Yes\_\_\_\_ No\_\_\_\_  
 If yes, to whom and when? \_\_\_\_\_  
 Were you given assistance or denied assistance, explain?
  
4. Are you a veteran? Yes\_\_ No\_\_\_\_ If yes, are you receiving VA benefits?
  
5. If Roswell SERTOMA provided only one hearing aid could you raise money for the second hearing aid? Yes\_\_\_\_ No\_\_\_\_
  
6. Is this your first application to Roswell SERTOMA assistance? Yes\_\_\_\_ No\_\_\_\_
  
7. When was your hearing tested? Date \_\_\_\_/\_\_\_\_/\_\_\_\_  
 (Attach copy of audiology test and technology recommendation.)
  
- 8a. Have you worn hearing aid in the past? Yes\_\_\_\_ No\_\_\_\_  
 If yes, Left\_\_\_\_ Right\_\_\_\_ Both\_\_\_\_  
  
 What happened to your prior hearing aids(broken, lost, stolen, etc)?
  
- 8b. If answered YES to question 8a , how old are the hearing aids?

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Signature (Patient / Guardian)

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Date