APPLICATION INSTRUCTIONS

Please complete the application and attach copies of **all** supporting documents. Any incomplete application will be returned. Once completed, please send to our address:

1317 Glenwood Dr.
Cleburne, TX
76033

If you have any questions about your application, please contact info@ephphatha8foundation.org or call 817-641-3750

SUPPORTING DOCUMENT CHECKLIST:

- IRS Tax Returns for the last two years
- Earning statements for the last two years:
  - W-2's, 1099s, IRA or 401k
  - Social Security/Disability if on a fixed income
- Bank statements for the last three months:
  - Checking
  - Savings
- Copy of medical insurance cards if applicant is insured
  - (Commercial, Medicare or Medicaid)
- Copy of Driver's License or another official ID
- Recent Hearing Evaluation (if applicable)

*If there is anyone over 18 living in the house with the applicant, their income information with supporting documents from the list above is required.

ELIGIBILITY INFORMATION

Ephphatha 8 Foundation envisions hearing improvement for people of all colors and creeds in Cleburne, Texas and the surrounding areas. Eligibility to receive funds for hearing services and devices is based solely on financial and situational need. Since we are a small operation, we must ask qualifying individuals to utilize their options through Texas Workforce Solutions-Vocational Rehabilitation Services, Medicaid, and/or Veterans Affairs to receive hearing aid devices **before** applying for aid through Ephphatha 8 Foundation.

Having insurance does not affect your eligibility to receive assistance through Ephphatha 8 Foundation.

LIMITATIONS:

- If you are at least 16 years of age and are employed or are seeking employment, then you may qualify to receive hearing aids through Texas Workforce Solutions-Vocational Rehabilitation Services (TWS-VRS), formally known as DARS. To locate an office near you, visit:
  https://webp.twc.state.tx.us/services/VRLookup/
  Email: vr.office.locator@twc.texas.gov
  Call (512) 936-6400

- If you are receiving Medicaid, then you may qualify for hearing aid coverage. Please contact member services or speak with your Primary Care Provider to find a hearing provider in your network.

- To find out if you have VA benefits near you, please visit
  https://www.mentalhealth.va.gov/

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PATIENT NAME: _____BIRTHDATE:___/___/___

Patient's address:_____

Phone:_____Email:_____

Patient's SSN#_____

Patient's State of Residence _____ Patient's Country of Citizenship _____

***If Patient has insurance—** Insurance Name: _____
Insurance ID#: _____ Insurance Group #: _____

ELIGIBILITY CHECKLIST

- Do you have Medicaid? _____
  If so, you may be ineligible to receive funds from E8F for hearing aid devices. Please see our eligibility page info.

- Are you at least 16 years of age and employed or seeking employment?
  _____
  If so, you may be ineligible to receive funds for hearing aid devices from E8F. Please see our eligibility page info.

- Do you have VA benefits? _____
  If so, you may be ineligible to receive funds from E8F unless you have extenuating circumstances that deter you from receiving those benefits (i.e., location/mobility). Please see our eligibility page info.

- Have you worked with TWS-VRS (formally DARS) in the past? _____
  If so, when? _____

- Who referred you to Ephphatha 8 Foundation? _____

- Have you had a recent hearing test? _____ If so, please include this with your application.

Please specify the type of assistance the patient needs (hearing aids/medical treatment):

_____

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FINANCIAL STATEMENT

*All items must be completed or this form will be returned without action.

1. How many people live in the household with the patient? _____
2. What is the net monthly income (take-home pay, after taxes) from all sources in the household, including public assistance? _____
3. What are the total monthly expenses for the household (including: house payment, electricity, gas, water, laundry, groceries, gasoline and monthly payments on loans or accounts)?_____
   If greater than the amount in Line 2, please explain: _____

_____

4. What is the total indebtedness for the household (money owed to banks, finance companies, and charge accounts)? _____
5. What is the total value of all property (including house, land, and automobiles)?

_____

6. Are there any other sources of money to pay for the hearing assistance and/or other services (private insurance, Medicaid, etc.)? _____
7. Is the family receiving any type of public assistance? Yes _____ No _____
   Food stamps? Yes _____ No _____ Rent subsidy? Yes _____ No _____

If there is anyone over 18 living in the house with the applicant, please provide their name and contact information, in addition to their income information with supporting documents listed above.

Name _____

Phone _____

Name _____

Phone _____

Name _____

Phone _____

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I certify that the above information is, to the best of my knowledge, true and correct and agree to provide current proof of income whenever requested to do so. I understand that the fee determined for this patient is subject to change upon a change in my income or a change in the Sliding Scale Fee. I further understand that failure to provide adequate proof of income will make me ineligible for the Sliding Scale Fee and the fee for this patient will then automatically become EPHPHATHA 8 FOUNDATION's fee. If approved for assistance, I understand that it is my responsibility to provide updated financial information each calendar year.

_____ _____

Signature of Patient/Applicant Date