

Patient Support Initiative Program

Dear Valued Patients,

Let Them Hear Foundation is a non-profit charitable foundation, which does not contract with any insurance companies. Payment for services rendered in Let Them Hear Foundation is required at the time of your appointment. Should you find yourself in a situation of financial hardship in covering the cost of these services, we would like to know. We have implemented a sliding fee scale (application attached) and you may qualify for a discount on our fees based on this scale. Submit the completed application and supporting documentation to the Committee for the Patient Support Initiative. Sliding fee scale discounts are good for the year you applied in and must be renewed annually. Please remember the program is a courtesy and it is patient responsibility to submit applications in a timely manner.

If you have an appointment with Let Them Hear Foundation, you must submit a completed application WITH supporting documentation at least two weeks prior to your appointment, NO EXCEPTIONS. We are unable to grant discounts retroactively.

Please remember this discount can only be applied only towards services at Let Them Hear Foundation. It can not be applied towards equipment, supplies or repairs needed for your cochlear implant or hearing aids (i.e. batteries, cords, etc.)

Future applications can be downloaded at the following website:

<http://www.letthemhear.org/other/pdfs/sliding-scale-app.pdf>.

Thank you.

Let Them HEAR Foundation

Patient Support Initiative

PLEASE NOTE THIS IS SEPARATE FROM THE ADVOCACY PROGRAM

Please send this form to:

Let Them Hear Foundation

Attention: Patient Support Initiative

1900 University Ave., Suite 101

E. Palo Alto, CA 94303

(650) 462-3143-tel

(650) 462-3144-fax

Patient Name _____ Date _____

Name of Responsible Party _____ Relationship to Patient _____

Address _____
Street City State Zip code County

Please attach copies of your income tax returns for the past two years and recent paycheck stubs, SSI, SSD etc., verifying income and submit this information **no later than 2 weeks prior to your first appointment** for processing. Please send a copy of your current W-2, and include a copy of your 2007 & 2008 returns.

1. Annual adjusted gross income: 2007 \$ _____ 2008 \$ _____

2. Current income earned from employment:

Patient Occupation _____ \$ _____ Hour/Year

Spouse Occupation _____ \$ _____ Hour/Year

Father Occupation _____ \$ _____ Hour/Year

Mother Occupation _____ \$ _____ Hour/Year

If unemployed, monthly unemployment compensation amount \$ _____

How long unemployed _____ Unemployment remaining \$ _____

3. Other assets: Businesses, Cash, savings, stocks, bonds, CD's, second home, recreational vehicles, etc. (exclude retirement funds, i.e. IRA):

_____ \$ _____
\$ _____
\$ _____
\$ _____

4. Other income:

Please specify source _____ \$ _____

5. Total number in household: _____

Parent's current marital status: ___ single ___ married ___ separated ___ divorced ___ widowed

Applicant's current marital status: ___ single ___ married ___ separated ___ divorced ___ widowed

Patient's ethnicity (optional): Caucasian/White Hispanic/Latino Native American/Alaskan Native
 African American/Black Asian Other

Parent's level of education _____ high school _____ Associate's degree
_____ GED _____ Bachelor's degree
_____ trade school _____ Master's degree
_____ community college _____ Doctorate

Applicant's level of education _____ high school _____ Associate's degree
(for applicants 18 yrs & older) _____ GED _____ Bachelor's degree
_____ trade school _____ Master's degree
_____ community college _____ Doctorate

MONTHLY EXPENSES

Home: Own Mortgage payment \$ _____ Property taxes/monthly \$ _____ Monthly payment \$ _____
 Rent Rent paid to: _____ Monthly payment \$ _____
Utilities/month: \$ _____

MEDICAL BILLS

Monthly medical costs (include explanation and name of doctor/hospital/clinic)

\$ _____

\$ _____

\$ _____
Total monthly expenses \$ _____

INSURANCE COVERAGE

(Please submit copy of front and back of insurance card)

PRIMARY INSURANCE

Insurance Company Name _____
Subscriber Name _____
Subscriber ID # _____
Group or policy # _____
Subscriber date of birth _____
Relationship to patient _____

SECONDARY INSURANCE

Insurance Company Name _____
Subscriber Name _____
Subscriber ID # _____
Group or policy # _____
Subscriber date of birth _____
Relationship to patient _____

Certification: I (we) certify that all the information on this form is true and complete to the best of my (our) knowledge. If asked by any authorized official of Let Them Hear, I (we) agree to give documentation for information given on this form. I (we) realize that failure to comply with a request for further information may prevent the applicant from receiving any aid. I hereby authorize the Committee for the Patient Support Initiative or any other investigative agency employed by the Let Them Hear Foundation to investigate the references herein listed or statements of other data obtained from me or from any other person pertaining to my credit and financial responsibility. I understand that if I am approved for a discount I may be required to provide explanation of benefits from my insurance carrier for my appointments.

Applicant's signature _____ Date ____/____/____

For internal use only

Level	1	2	3	4	Fund _____
Approved by _____					Date _____