Citrus Hearing Impaired Program Services

109 NE Crystal Street Suite B, Crystal River FL 34428
352-795-5000

Enclosed is an application for our Hearing Aid Assistance Program.

Citrus Hearing Impaired Program Services (C.H.I.P.S.) is a non-for-profit agency that offers many services and programs to the Deaf and Hard of Hearing in our community. Our Hearing Aid Assistance Program is designed to help those individuals who cannot afford to purchase new hearing aids. We work in conjunction with participating Audiologists and Hearing aid providers to provide new or refurbished hearing aids to those who qualify.

This application helps us determine those who are truly in need and who will benefit from this program.

Please carefully fill out the application and be sure all documentation is included before returning it to our office. If you qualify, we will contact you to schedule an appointment with a provider for an evaluation. Funding is always limited and if funds are not available, we will keep your application for 6 months and notify you when funds are available again.

Please pay attention to the following points of interest:

1.) Your applications will not be considered until all the documentation from the checklist is included and all pages are completely filled out.
2.) If it is determined that you will have a co-pay (of up to $500), this amount must be paid in full before your first visit to the provider you have been assigned to. (See guidelines to determine co-pay amount.)
3.) If you have insurance, including Medicaid or Medicare, that covers the cost of hearing aids, you will not be considered for this program.
4.) We take into consideration the financial situation of everyone that lives in the house with you, even if you support yourself.
5.) You must be a full-time resident in Citrus County.

Feel free to call us if you have any questions about the program or help with filling out your application. Out phone number is 352-795-5000.

Sincerely,

Maureen Tambasco
Executive Director

Citrus Hearing Impaired Program Services

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Date: ____________________

Applicant's Name:

First_________________________Middle__________________Last______________________

Date of Birth_________________________ Gender Male/Female

Marital Status: Single / Married / Divorced / Widowed

Permanent Address:____

Mailing Address____

Home Phone:____________________________ Cell Phone:_____________________________

E-mail:____

Number of People in the Household:_________

Names of Dependents: Ages:

____ ___________

____ ___________

____ ___________

Applications are chosen on a as needs basis and only when ALL applicant's paperwork is completed and all proper documentation is turned in.

Employment Status: ☐ Employed ☐ Other ☐ Retired

Name of Current Employer: ____

Phone: _______________________ How long have you been employed there? ____________

I understand the information I submit to C.H.I.P.S. concerning my annual income, family size, family resources, insurance, medical history and all financial information is subject to verification by C.H.I.P.S. and/or their agents. This verification will be done by phone, letter, e-mail or credit check**. I understand that if I knowingly omit or submit false information, I will be denied consideration for assistance at any point during the process.**

Applicant Name:____________________ Applicant Signature: _______________________

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Persons in Household	**Annual Gross Income 2020**				
	A	B	C	D	E
1	$12,760	$16,971	$17,609	$19,140	$25,520
2	$17,240	$22,929	$23,791	$25,860	$34,480
3	$21,720	$28,888	$29,974	$32,580	$43,440
4	$26,200	$34,846	$36,156	$39,300	$52,400
5	$30,680	$40,804	$42,338	$46,020	$61,360
6	$35,160	$46,763	$48,521	$52,740	$70,320
7	$39,640	$52,721	$54,703	$59,460	$79,280
8	$44,120	$58,680	$60,886	$66,180	$88,240
Your Co-Pay	$0	$125.00	$250.00	$375.00	$500.00

In determining eligibility, C.H.I.P.S. considers the following:

Household size (Household is defined as the number of people living in the house).
Net Monthly or Annual Income from all in the household who have income will be taken in to considerations. **Proof of all income is REQUIRED.**

Possible source of income are:

Social Security	SSI	Child Support	Alimony
Stock Interest	IRAs	401(k)	VA Pension
Public Assistance (including help from outside the home)	AFDC	Wages	Unemployment
Workman's Compensation	Food Stamps	Disability	Work Pension

APPLICATION FOR HEARING AID ASSISTANCE

Applicant Name____

ANSWER ALL QUESTIONS AND INCLUDE ALL DOCUMENTS

☐ Provide 3 months of current income statements to include the following:

• Social Security	SSI	Child Support	Alimony
• Stock Interest	IRAs	401(k)	VA Pension
• Public Assistance	AFDC	Wages	Unemployment
• Workman's Comp.	Food Stamps	Disability	Work Pension

☐ Provide 3 months of current bank statements to include the following:

Checking and Savings

☐ Provide a copy of your valid Driver's License or State ID.

☐ Do you have health insurance or Medicaid or Medicare? ☐ YES ☐ NO

If yes, please let us know if they if they offer a benefit for hearing aids and how much that benefit is.

Applicant:

A. Source of Income _______________________________ $ __________________ Month or Year (Circle One)

B. Source of Income _______________________________ $__________________ Month or Year (Circle One)

Spouse/Other:

C. Source of Income _______________________________ $ __________________ Month or Year (Circle One)

D. Source of Income _______________________________ $__________________ Month or Year (Circle One)

*Additional information may be needed after initial review of the application.

**C.H.I.P.S. reserves the right to change criteria at any time without prior written notice.

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Hearing Aid Assistance Program

ONE OF THE FOLLOWING MUST BE COMPLETED AND SUBMITTED WITH THE APPLICATION

OPTION 1: MEDICAL CLEARANCE FOR HEARING AID USE

TO BE SIGNED BY APPLICAT'S MEDICAL DOCTOR

Date: ____________________

Applicant Name ____

Applicant's Name (please print):_______________________________________

The applicant listed above has been medically examined and may be considered a candidate for hearing aid use.

Physician's Name (please print): _______________________________________

Physician's Signature: ____

EITHER OPTION CAN BE USED

OPTION 2: WAIVER OF MEDICAL CLEARANCE FOR HEARING AID USE

TO BE COMPLETED AND SIGNED BY THE APPLICANT

Date: ________________________

Applicant's Name (please print): ____

I understand that it is in my best interest and recommended by Citrus Hearing Impaired Program Services, Inc. and the Food and Drug Administration to receive a medical examination before acquisition of hearing aids. I choose not to receive a medical examination before acquiring hearing aids.

Applicant's Signature: ____