Help Me Hear Application

*Help Me Hear is a program to assist patients in obtaining hearing aids only. Other charges apply.

Name: _____

Address: _____

Phone: _____

Birthdate: _____ Age: _____

Marital Status (please circle): Single Married Widowed Divorced

Number of people in your household: _____

Total Household Monthly Income: $_____

Source(s): _____

Total Monthly expenses: $_____

Current or Last Employer: _____ # years: _____

Students – School or College: _____

Health Insurance Plan Name(s): _____

Please briefly describe the type of hardship(s) that prevents you from purchasing hearing aids and how you expect to benefit and use the hearing aids:

_____
_____
_____
_____
_____
_____

_____
Signature Date

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