Application
Hearing Aid Distribution Program (HADP)

Dear Applicant:

Attached is the application for the Hearing Aid Distribution Program (HADP), which provides assistance to households at or below federal poverty guidelines. This program is administered by the Missouri Commission for the Deaf & Hard of Hearing (MCDHH). Availability is subject to funding.

Some items such as implants (cochlear of Baha), therapy services or equipment, and medical supplies are not available through the HADP program. *Please check on whether an item is eligible for consideration before completing an application.*

Funding is not available for any portion that is the responsibility of another agency (i.e. private insurance, Medicare Part C, Medicaid, etc.). If cost exceeds our award amount, any contributing funding that has been committed must be documented and included with the application.

Awards are limited to a maximum of $3,900 for a pair and $1950 for one hearing aid. Because of the large number of requests and limited funds, applications will be prioritized based on demonstrated need and if other resources have been exhausted. Demand is far greater than our funding, so please understand that a cost-effective quote will free up more funding for others.

The current (2021) federal income limits are: Effective (01/12/2022)

Household Size	Income Guideline**
1	$13,590
2	$18,310
3	$23,030
4	$27,750
5	$32,470
6	$37,190
7	$41,910
8	$46,630
9+	Add $4,540 for each person

** Note: if you are above the household income limits, please let us know about significant recent out-of-pocket medical expenses or other expenses you may have had in your household.

Please return the completed form to:

HADP Program Manager
MCDHH
3216 Emerald Lane, Suite B
Jefferson City, MO 65109

You will sent an acknowledgement letter upon receiving your application. It can take some time for funding to become available and for applications to be reviewed by the HADP committee.

Your Application must be COMPLETE before it can be reviewed.

Please send the following documents:

1. **This Application** (note: this program is only for residents who have lived in Missouri for a minimum of one year)
2. **Written Quote From Hearing Aid Vendor –** Quote must include the entire price of the hearing aid(s) and cost of future follow up visits. It should also include warranty information [minimum one-year warranty] and have at least a 30-day trial period. Quote must be completed by a licensed Missouri vendor.
3. **Recent Audiogram (within last 6 months)** by a licensed audiologist or licensed hearing instrument specialist.
4. **Income Documentation –** Include one or more of the following:
    - **a** Most recent federal tax return
    - **b** One month pay check stubs
    - **c** Social Security benefit letter
    - **d** Documentation of recent events affecting income such as job loss or significant medical expenses.
    - **e** If one or more of these documents are not available, please contact our office.

If you have any questions or need more information, feel free to contact John Peterson, Hard of Hearing Program Manager, at (573) 751-3006 or Toll Free (855) 783-3177.

Web address: https://mcdhh.mo.gov/

HEARING AID DISTRIBUTION PROGRAM (HADP) APPLICATION

PART 1 of 4 - APPLICANT INFORMATION

_____ _____
Name (Last) Name (First, Middle Initial)

_____
Street Address

_____ Missouri _____ _____
City State Zip Code County

_____ _____
Home Phone Cell/Work Phone

_____ _____ _____ (Residency)_____
Date of Birth Age Total persons in household How long have you lived in Missouri?

_____ _____
(If under age 18) Parent(s)/ Guardian Name(s) printed Parent/Guardian Signature(s)

INCOME (Required: please attach relevant documentation to demonstrate income.)

$_____ **Adjusted annual income/AGI for household**
(Include most recent federal income tax return)

$_____***Social Security benefits for all household members***

$_____***Other untaxed income***

INSURANCE

Do you have private health insurance? ____ Yes ____ No

Please describe or attach any hearing aid benefits from your policy? _____

_____

Is applicant enrolled in MoHealth Net (Medicaid) or Medicare?

Applicant's Medicaid DCN#: _____

Medicare Part B or C Coverage? ____ Yes ____ No
(if yes, list/attach any hearing aid benefits)

PART 2 of 4 – OTHER RESOURCES

OTHER RESOURCES

Are you currently employed? _____ Occupation: _____

Can MCDHH refer your contact information for possible eligibility for hearing aids with other agencies/programs (such as other government agencies or local programs)?

- Yes
- No
- Please contact me first

Were you referred to HADP by a Vocational Rehabilitation Counselor? ____ Yes ____ No

Has funding been sought from any other sources or programs? ____Yes ____No
Mark those that apply:

- ____ Private organizations
- ____ Missouri Vocational Rehabilitation
- ____ Missouri Assistive Technology
- ____ Other: _____

If there is contributing funding or hearing aid benefits, they must be documented and attached to the application.

PART 3 of 4 – PROVIDER AND HEARING AID INFORMATION

Do you currently wear hearing aids?

- Yes
- No
- Have in the past, but not currently

If yes, how old are your hearing aids? _____

Hearing Aid Provider Name/License #:_____

*(*Provider must be a licensed Audiologist or Hearing Instrument Specialist)

ATTACHMENT 1 (REQUIRED): A recent audiogram (no more than 6 months old) with a written summary of hearing loss from provider, including:

- Description and history of applicant's hearing loss that requires hearing aids.
- Audiogram must include air and bone conduction, and speech discrimination.
  - Please Note: Audiogram must be less than 6 months old. Make sure date of audiogram is present.
- Does applicant need medical clearance from a physician based on audiogram results?

ATTACHMENT 2 (REQUIRED): An official quote with:

- Who provided assistance in selecting the hearing aids.
- Hearing aid(s) make, model, and price
  - ***Must not exceed $3,900 for pair or $1950 for one hearing aid***.
- Fitting/follow up costs (if any)
- Minimum 1 (one) year warranty (and how covered) with 30-day trial period.
- Provider contact information (name, address, email, and phone number)

PART 4 of 4 – OTHER INFORMATION

How will hearing aid(s) improve your life? Attach an additional sheet if needed.

How did you learn about this program?

Did you have help in completing this application? (If so, please list the person/agency that helped and their phone number)

Why did you choose to obtain hearing aids through the Hearing Aid Distribution Program (HADP)? Any other information you would like us to consider?

I Certify that the above is true to the best of my knowledge.

Applicant Signature_____***Date***_____

Applications will be accepted by US Mail or Fax.

(Note: if application is faxed please follow up with us to make sure we have received it.)

Mail Completed Application to:

HADP Program Manager
MCDHH
3216 Emerald Lane, Suite B
Jefferson City, MO 65109

Fax: 573-526-5209

Questions? Phone: 573-526-5205 or 1-855-783-3177