



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.

The Department of Elementary and Secondary Education does not discriminate on the basis of race, color, religion, gender, gender identity, sexual orientation, national origin, age, veteran status, mental or physical disability, or any other basis prohibited by statute in its programs and activities. Inquiries related to department programs and to the location of services, activities, and facilities that are accessible by persons with disabilities may be directed to the Jefferson State Office Building, Director of Civil Rights Compliance and MOA Coordinator (Title VI/Title VII/Title IX/504/ADA/ADAAA/Age Act/GINA/USDA Title VI), 5th Floor, 205 Jefferson Street, P.O. Box 480, Jefferson City, MO 65102-0480; telephone number 573-526-4757 or TTY 800-735-2966; email civilrights@dese.mo.gov.

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 Amber Carter, Hard of Hearing Program Manager, at (573) 355 – 9565.

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

HEARING AID DISTRIBUTION PROGRAM (HADP) APPLICATION

PART 1 - APPLICANT INFORMATION

Name (Last)

Name (First, Middle Initial)

Street Address

City

Missouri
State

Zip Code

County

Home Phone

Cell/Work Phone

Date of Birth

Age

Total persons in household

(MO/YR)
How long have you lived in Missouri?

PART 2 – INCOME INFORMATION

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

<input type="checkbox"/>	Adjusted Annual Income (AGI)	\$	<input type="checkbox"/>	Social Security Income (SSI)	\$
<input type="checkbox"/>	Wages/Salaries/Tips	\$	<input type="checkbox"/>	Social Security Disability (SSDI)	\$
<input type="checkbox"/>	Other Financial Loss/Expenses	\$	<input type="checkbox"/>	Other Untaxed Income	\$

PART 3 – INSURANCE INFORMATION

<input type="checkbox"/>	Private Health Insurance	
<input type="checkbox"/>	Medicaid	Medicaid DCN#:
<input type="checkbox"/>	Medicare A, B, C, or D	If yes, list/attach any hearing aid benefits:

PART 4 – OTHER ASSISTANCE SOUGHT

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

Were you referred by a Vocational Rehabilitation Counselor?

Yes

No

Missouri Vocational Rehabilitation

Yes

No

Missouri Assistive Technology

Yes

No

Have you sought funding from any other sources or programs?

Yes

No

If there is funding received from other sources or programs, please list here:

PART 5 – PROVIDER AND HEARING AID INFORMATION

Provider must be a licensed Audiologist or Hearing Instrument Specialist in Missouri.

Hearing Aid Provider Name:

Hearing Aid Provider License:

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

- Description of hearing loss and/or history of hearing loss that requires hearing aids:

- What model and brand of hearing aids are being sought?

- Who provided assistance in selecting the hearing aids?

ATTACHMENT 2 REQUIRED: An official quote (attach the written quote and documentation):

- **Hearing aid(s), make, model, and price**
 - **MUST not exceed \$3,900 for pair or \$1,900 for one hearing aid.**
- **Fitting and follow up cost (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 6 – OTHER INFORMATION

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)

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

How will the hearing aid will improve your life?

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