Application for Hearing Aid Distribution Program (HADP)
Missouri Commission for the Deaf & Hard of Hearing

Dear Hearing Aid Distribution Program Applicant:

Attached is the application for the Hearing Aid Distribution Program (HADP). This program provides assistance to those whose household income is at or below the federal poverty guidelines. This program was created as a result of Senate Bill 101 (2019) and is administered by MCDHH with funding made available subject to appropriations and grant availability.

Items such as (cochlear implants, services or equipment used in therapy, and medical supplies) are not available through the HADP program. *Persons may 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, Medicaid, etc.).

Awards are limited to $3,900 for a pair and $1950 for one hearing aid. Because of the expected number of requests for hearing aids and limited funds available, applications will be prioritized based on demonstrated need and other resources that have been exhausted.

If cost exceeds our award amount, any contributing funding that has been committed must be documented and included with the application.

Please let us know about significant recent out-of-pocket medical expenses you have had in your household. Consideration will be given to applicants living at or near the federal poverty guidelines and who have incurred additional expenses during 2019 in their household including: medical, financial/job loss that can be documented.

Please return the completed form to:

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

Applications will only be accepted by US Mail.
No applications will be accepted electronically or by email.

You will be notified as to whether funding is available for your request once applications have been prioritized and reviewed by the HADP committee.

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

Web address: mcdhh.mo.gov

Your Application must be COMPLETE before your application is considered. Review your application before sending it to our office.

You will need to attach the following documents:

1. **From Hearing Aid Vendor - A written quote that includes (the entire cost of the hearing aid(s), any future follow up visits, how items that wear out will be covered [labor & parts], minimum one-year warranty and 30-day trial period) must be completed by the licensed vendor in Missouri and included with your application.** ***(A Purchase Agreement between the vendor and the HADP client should be included with the Invoice to MCDHH that outlines each of these items as well as the make/model and serial numbers. Please include how the hearing aid(s) can be stored and maintained appropriately.*****)**
2. **Written verification of your audiogram by a licensed audiologist or licensed hearing instrument specialist. Review the attached HADP Overview to be sure you are eligible.**
3. **Income documentation that verifies your total annual income. This could be last year's tax return, one month of pay check stubs, evidence of job loss, or a benefit letter (if these are not available, contact our office).**

If you are unsure of what to include, call our office and ask for Kristin Funk, Hearing Healthcare Program Manager at (573) 526-5205.

HEARING AID DISTRIBUTION PROGRAM (HADP) APPLICATION FORM

PART 1 - APPLICANT INFORMATION

______________________________ ____
Name (Last) Name (First, Middle Initial)

____
Street Address

______________________________ Missouri _______________ ____________________
City State Zip Code County

__________________________________ ____
Home Phone Cell/Work Phone

___________________ _________ ___________________ (Month)________(Yr)________
Date of Birth Age Total persons in household Resident of Missouri since (Mo/Yr)

____
Family occupation(s)

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

$____________________ Adjusted annual income/AGI ***(Include most recent federal income tax return)***

$____________________Household Wages, salaries and tips (before withholding)

$____________________Household UNTAXED INCOME-Social Security benefits for all members

$____________________Other untaxed income
I Certify that the above is true to the best of my knowledge.

Client Signature____Date___________________________

Does applicant have private health insurance? ____ Yes ____ No
If "Yes", please list insurance company: ____

Is applicant enrolled in MoHealth Net or any Medicaid/Medicare?

Applicant's Medicaid DCN#: ________________________

Medicare Part B Coverage? ____ Yes ____ No (if yes, list any Medicare Advantage plan)

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

Has funding been sought from any other sources or programs? ____Yes ____No

If funding been sought from any other sources, mark those that apply: ____ Private organizations

____ Missouri Vocational Rehabilitation ____ Missouri Assistive Technology

Other sources or programs: ____

PART 2 – HEARING AID INFORMATION

Attach Recent Audiogram (within 6 months) from licensed Audiologist or Hearing Instrument Specialist:

*Professional's License #:*___________________________

(Please include confirmation of a recent audiogram and written summary of hearing loss and need for hearing aids from either a licensed Audiologist or licensed hearing instrument specialist within the past 6 months) including:

Description and history of applicant's hearing loss that requires hearing aids:

What model, brand, serial # is being sought? (Hearing aids must be new and not re-furbished.)

Who provided assistance in selecting the hearing aids?

How will the device improve the individual's life *(i.e. improve functional abilities, remove barriers to daily living activities; improve ability to interact with others, etc)*? Attach an additional sheet if needed.

Please list the vendor/provider/contractor from whom you plan to obtain the needed device. Include the vendor's name, address, and phone number:

You must include with your application an official quote for the hearing aid(s). This quote should come from the vendor/contractor you are intending to get the item from and should include exact specifications.

The total amount needed for the hearing aids: $__________ . (Must not exceed $3,900 for pair or $1950 for one hearing aid.)

Note: If there is contributing funding, this must be documented in writing and attached to the application.

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)

Please answer the following questions about the funding assistance you are applying for through the Hearing Aid Distribution Program (HADP).

The primary purpose for which I need hearing aids is related to:

(Please mark only one answer)

- ☐ **Community living**---carrying our daily activities, participating in community activities, using community services, or living more independently.
- ☐ **Employment**---finding or keeping a job; getting a better job; participating in a training program, or other program related to employment.
- ☐ **Education**---participating in any type of educational program.

Why did you choose to obtain hearing aids through the Hearing Aid Distribution Program (HADP)?

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Mail Completed Application to:

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

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

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