

**Massachusetts Department of Public Health
Bureau of Family Health and Nutrition
Hearing Aid Program for Infants and Children
250 Washington Street, 5th Floor
Boston, MA 02108
1-800-882-1435 or 781-234-5836**

APPLICATION INSTRUCTIONS:

The application should be completed and signed by a parent, guardian, or the applicant (only applies when the applicant is not claimed as a dependent on another tax form). **WRITTEN DOCUMENTATION OF INCOME MUST BE PROVIDED.** Once the completed forms and documentation are reviewed, a price quote from a participating hearing aid dispenser will be requested.

The following is a list of definitions of terms used on this form. If you need assistance or more information regarding the program, please call the numbers listed above.

DEFINITIONS OF TERMS:

APPLICANT: The child or young adult up to age 21 who will be using the hearing aid.

FAMILY SIZE: The following people should be included in the determination of family size:

- a. The applicant;
- b. Each dependent of a parent or guardian of the applicant if the parent or guardian lives in the same household as the applicant and the applicant is less than 18 years of age;
- c. If the applicant is 18 years of age or less, each parent or guardian of the applicant who lives in the same household with the applicant;
- d. Each person of whom the applicant is a dependent;
- e. If the applicant is married and lives in the same household with her or his spouse, the applicant's spouse.

DEPENDENT: A person who may legally be claimed as a dependent on the federal tax return of another person, (that is, someone who receives more than 50% of their support from that person).

ANNUAL GROSS INCOME: The sum of all before-tax income expected to be received during the twelve month period, which commences on the date of application.

1. Annual gross income includes, but is not limited to, the following:
 - a. wages, salaries, tips, and commissions
 - b. net earnings from self-employment, partnerships or business
 - c. net rental income
 - d. dividends
 - e. interests
 - f. annuities
 - g. pensions
 - h. royalties
 - i. government benefits including, but not limited to, Department of Transitional Assistance, Social Security, Supplemental Security Income, Unemployment Compensation, Worker's Compensation, and Veterans Administration
 - j. alimony and child support payments received
 - k. scholarships and fellowships not used for tuition

2. The following items are not counted in determining gross income:
 - a. gifts and inheritances received
 - b. withdrawals from bank accounts
 - c. money borrowed
 - d. capital gains from a one-time sale
 - e. lump sum payments
 - f. life insurance payment paid by reason of death of the insured
 - g. scholarship and fellowships for tuition

VERIFICATION OF APPLICATION INFORMATION

1. The applicant shall provide some form of written documentation that indicates that the statements concerning income on the application form are correct. The preferred form of written documentation shall be the most recent federal tax form (including W-2s) of those persons whose income is counted in determining income. Written verification of income not included on federal tax forms must be submitted.
2. The applicant shall supply verification in the form of receipts or copies of billing statements for all medical bills (including dental) paid or incurred during the past twelve months.

The application can be submitted by you or your child's audiologist via email to sarah.stone@mass.gov or fax 857-323-8318.

HEALTH INSURANCE INFORMATION

Please provide the following information:

INSURANCE INFORMATION

INSURANCE COMPANY: _____

POLICY #: _____

TELEPHONE #: _____

EFFECTIVE DATE OF POLICY: _____

NAME OF POLICYHOLDER: _____

Is the applicant covered by MassHealth Limited: YES _____ NO _____

Does the policy provide any benefits toward the cost of hearing aids? YES ____ NO _____

If yes, please explain: _____

MEDICAL PROVIDER MUST SUBMIT PROOF OF APPLICANT'S INSURANCE

AUDIOLOGY CENTER/HEARING AID DISPENSER INFORMATION

Center where applicant received hearing aid evaluation:

CENTER NAME: _____

AUDIOLOGIST NAME: _____

TELEPHONE #: _____

Hearing Aid Dealer or Hearing Aid Dispensing Center where you plan to obtain the hearing aid(s):

NAME: _____

TELEPHONE #: _____

Has this applicant received a hearing aid from the Department of Public Health in the past?

YES _____ NO _____

If yes, please provide the date that the hearing aid was received: _____

FAMILY HEALTH CARE

List medical bills (including dental) paid or incurred by the family during the past twelve months. (Do NOT list bills paid by health insurance, MassHealth (Medicaid), etc.) Please attach documentation of such expenses.

DATES OF SERVICE: _____ **NAME OF PROVIDER:** _____ **AMOUNT**

COST OF HEALTH INSURANCE PREMIUMS FOR THE PAST TWELVE MONTHS

\$ _____

SIGNATURE OF APPLICANT OR PARENT/GUARDIAN

DATE