Olive Osmond Hearing Fund

"Bringing Music to Your Ears"®

HERE 2 HEAR

2025 Application

(Valid through Dec 31, 2025)

www.HearingFund.org

Olive Osmond Hearing Fund

"Bringing Music to Your Ears."

Dear Applicant,

Thank you for contacting the Here 2 Hear program through the Olive Osmond Hearing Fund. This program provides hearing aids to those who otherwise can't afford, and have no other resources available to get amplification. Our program has specific requirements and each application will be reviewed to make sure they fit those requirements. Reviews typically are done quarterly, and sometimes sooner as funding becomes available. ***Please reach out to other resources for assistance, which include: family support, insurance, state Medicaid program, vocational rehabilitation, school district, VA, church groups, state or local programs.***

The Here 2 Hear program provides hearing devices through your own audiologist. Any additional services that include, but are not limited to exams, fittings, molds, etc., **unfortunately, *are not provided*** unless specifically included in the approval letter. So we would recommend that you ask the person fitting you to donate their services, or make payment arrangements with them for their services if you are approved as an applicant. Assistance from OOHF comes through donations, grants, manufacturer and/or dispenser gifts, sponsors and other such public support.

Only those who fall within the program guidelines for income, assets and hearing loss can be considered for assistance. **Incomplete applications will be immediately denied.** The hearing health care provider will assist the applicant in determining the number of aids needed to best help the applicant to hear.

Every application is reviewed and considered within the quarter it is submitted. The review process can take up to 3 months before determination is made. Once reviewed, you will be contacted, via email or phone, by a Here 2 Hear representative. If you have been approved your approval letter will let you know what the process will entail. If you have been denied, you will be given the option to resubmit your application for the next quarter. ***We do give preference to children when reviewing applications. We do offer assistance to adults as well, but only as our funding and resources allow.***

Thank you, and feel free to contact us if you have any questions or concerns.

Olive Osmond Hearing Fund
Here 2 Hear Program
P.O. Box 910065
St. George, UT 84791
(801) 609-4327
info@hearingfund.org
www.hearingfund.org

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APPLICATION INFORMATION

1. Income Guidelines: All income is based on your NET income. NET income is the amount you actually receive in your check(s) regardless of the source (take home pay).

PERSONS IN FAMILY OR HOUSEHOLD	48 CONTIGUOUS STATES AND D.C.	ALASKA	HAWAII
1	$19,547	$24,447	$22,505
2	$26,477	$33,110	$30,467
3	$33,407	$41,772	$38,430
4	$40,337	$50,435	$46,392
5	$47,267	$59,097	$54,335
6	$54,197	$67,760	$62,317
7	$61,127	$76,422	$70,280
8	$68,057	$85,085	$78,242
EACH ADDITIONAL PERSON	$3,960	$4,950	$4,550

2. In determining eligibility, the Here 2 Hear program considers the following: all available funds, assets, insurance/resources available and hearing loss.
    a. **Household Size** (Household is defined as those living together or dependent on each other).
    b. **Net Monthly or Annual Income** from all in the household who have income. Possible sources of income are:
        - Social Security and SSI
        - VA Pension
        - Child Support
        - Public Assistance
        - Alimony
        - Welfare
        - Wages
        - AFDC
        - Disability
        - Work Pension
        - IRAs, 401(k)s
    c. **Assets/Resources** (include, but not limited to):
        - Medical Insurance/Union Assistance
        - Checking
        - Money Market
        - Annuities
        * Family/Friends Assistance
        - IRAs, 401(k)s
        - Savings
        - Home Equity Loan

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Here 2 Hear reserves the right to change eligibility criteria without prior written notice.

GENERAL INFORMATION *(Please Print Clearly)* Date: _____

Applicant's Name (person who would receive hearing device):
First: _____ Middle Initial: ___ Last: _____
Date of Birth: _____ Age: _____ ☐ Male ☐ Female
Social Security Number: _____

Marital Status: ☐ Married ☐ Single ☐ Divorced ☐ Widowed ☐ Separated
Number in Household: _____ (Defined as all living together or dependent on each other.)

Mailing Address:
Street: _____ Apt. # _____
City _____ State: _____ ZIP: _____
Home Phone: _____ Cell Phone: _____
Email Address: _____

If applicant is a Minor, Parent/Guardian's Name(s):
_____

Person, if other than applicant, completing this form. If Minor, list Parent/Guardian's Information
Name: _____
Relationship to Applicant: _____
Phone: _____ Email: _____

INCOME
If applicant is a Minor, list Parent/Guardian's income information
List all sources of income (i.e., salary, social security, alimony, child support, pension, stocks, bonds, etc.) for all in the household. **Please state the take home (net) pay.**

Applicant:
A. _____ $_____ Month or Year (circle one)
B. _____ $_____ Month or Year (circle one)
C. _____ $_____ Month or Year (circle one)
Spouse/Other:
A. _____ $_____ Month or Year (circle one)
B. _____ $_____ Month or Year (circle one)
C. _____ $_____ Month or Year (circle one)

Are you a Medicaid recipient? ☐ Yes ☐ No
Do you have medical insurance? ☐ Yes ☐ No If yes, are hearing devices covered? ☐ Yes ☐ No
Do you have union or other assistance benefits? ☐ Yes ☐ No If yes, explain_____
Do you have family/friends willing to help? ☐ Yes ☐ No If yes, explain_____

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Applicant Name: _____

ADDITIONAL INFORMATION

Mark 1 box for each item. Unanswered questions will cause application to be denied.

Do you currently have:

	Yes	No
Checking Account	☐	☐
Savings Account	☐	☐
Credit Card	☐	☐
CD(s)	☐	☐
Stock/Bonds	☐	☐
Annuity	☐	☐
IRA/401(k)	☐	☐
Money Market Account	☐	☐

HOUSEHOLD INFORMATION

Household is defined as all those who live together or are dependent on each other.

Number in Household: _____

List names of individuals in household.

Name	**Age of Person**
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

Employment Status: ☐ Employed ☐ Other ☐ Retired

Name of Current Employer: _____

Phone: _____ How long have you been employed there? _____ (Years/Months)

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Applicant Name: _____

RELEASE INFORMATION

I understand the information I submit to OOHF concerning my annual income, family size, family resources, insurance, medical history and all financial information are subject to verification by OOHF and/or their agents. This verification will be done by phone, letter, e-mail or credit check. **I understand that if I knowingly omit or submit false information, I will be denied consideration for assistance at any point during the process.**

Applicant Name: _____
Applicant's Date of Birth: _____
Applicant Signature : _____

Spouse's Name: _____
Spouse's Date of Birth: _____
Spouse's Signature: _____

Guardian's Name: _____
Guardian's Date of Birth: _____
Guardian's Signature: _____

(If Minor, parent/guardian signature required)

If signed by power of Attorney (POA), please send copy of POA. The laws of the state of Utah shall govern the resulting transaction and any claim or dispute arising out of such transaction.

MEDIA WAIVER AGREEMENT

I, (print name) _____, authorize the Olive Osmond Hearing Fund (OOHF), the right to use my, or my child's, physical likeness and/or voice and/or visual imagery (photographs, moving footage, or other visual and/or audio media), interviews or other content provided to the OOHF , in perpetuity and throughout the world. This material will be distributed at the discretion of the OOHF to the media or shown in public venues for educational and marketing purposes. I represent that the consent of no other person, firm, corporation or organization is required to enable OOHF to use my, or my child's, likeness and/or voice and/or imagery as described herein, and that such use will not violate the rights of any third parties.
I hereby certify and represent that I have read the foregoing and fully understand the meaning and effect thereof, and intend to be legally bound by this release. I am over the age of 18 years of age and competent to contract in my own name, or on behalf of my child.

Name of recipient: _____ (print)
Recipient Signature: _____Date:_____

Guardian Signature: _____Date:_____

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Applicant Name: _____

MEDICAL/AUDIOLOGICAL INFORMATION

To be completed by the provider FITTING AIDS FOR CLIENT (Please Print Clearly)

Name of Patient:_____

Date of Birth:_____

PLEASE ATTACH & submit with application: Air and Bone Conduction Audiogram, SRTs, MCLs and UCLs

Is the client currently aided? ☐ YES ☐ NO

If yes, list make/model and how old? _____

Number of aids requested: _____ If fitting only one (1) ear, which ear are you fitting? _____
What device(s) are you recommending? _____
(Please state manufacturer and model. We have access to a few different manufacturers).
What is the cost for these aids? $_____ (Please include amount here, or attach an invoice)
If this manufacture and model isn't available, what is your second best choice for this patient?_____
_____

I agree to provide services in accordance with state/ federal guidelines. I understand that associates who receive hearing aids from Here 2 Hear Program for their client agree to provide the aids to the appropriate client. Charges related to the initial hearing evaluation, customary evaluation/hearing assessment fees are the client's responsibility.

PLEASE COMPLETE THIS SECTION FOR CLIENT

Name of Professional: _____

Name of Business: _____

Address: _____

City: _____ State:_____ ZIP:_____

Phone: _____ Email: _____

State Licensure/Registration #: _____

Signature: _____Date:_____

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MEDICAL CLEARANCE FOR HEARING AID USE *to be signed by client's primary physician*

Patient Name (please print): _____ Date: _____

The patient listed above has been medically examined and may be considered a candidate for hearing aid use.

Physician Name (please print):_____
Physician Signature: _____

OR

WAIVER OF MEDICAL CLEARANCE FOR HEARING AID USE *to be completed and signed by the client*

Client Name (please print): _____ Date: _____

I understand that it is in my best interest and recommended by Olive Osmond Hearing Fund and the Food and Drug Administration to receive a medical examination before acquisition of hearing aids. I choose not to receive a medical examination before acquiring hearing aids.

Client Signature: _____

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Summary Submission Page

Please tell us about yourself and the reason you are requesting assistance from the Olive Osmond Hearing Fund. Include any information you feel may be helpful to us in making a determination on your application (ie. future plans, interests, challenges, how these devices would benefit you, etc.) We would also love to have you submit a photo of yourself. (We like to see those we are helping, and if you are selected, we would likely also post your photo when you are fitted with your new aids to thank those donors who made it possible). Please keep your response to 1 page maximum.