



**Baton Rouge  
Speech & Hearing  
Foundation**

## Application for Financial Assistance

Client Name _____	DOB _____
Responsible Party _____	Phone - Home _____
Address _____	Work _____
_____	Cell _____
Social Worker or Care Attendant _____	Phone _____

The SPEECH AND HEARING FOUNDATION is a non-profit agency serving all people regardless of race, creed, ethnic origin, or level of income. The costs of services provided are based, to the greatest extent possible, on a person's ability to pay. To qualify for assistance, please fill in the information below. All information will be kept confidential.

The number of people living in your household \_\_\_\_\_. Their first names, ages, and relationship to you are:

**Income:** (Total for all members of the household)

**Assets:**

Amount Monthly / Yearly	Type of Income
	Wages
	Social Security and SSI
	Pensions
	Disability
	Alimony
	Child Support
	Welfare and Public Assistance
	Interest
	Dividends
	Capital Gains
	Other Income
	<b>Total</b>

Current Value	Description
	Checking
	Savings
	CDs
	Money Market
	Annuities
	Stocks
	Bonds
	Life Insurance Cash Value
	IRA/401(k)
	Other Assets
	<b>Total</b>

We must have the following documentation in order to process your application (copies, not originals):

- |  |   |
|--|---|
| _____ Pay stubs (last 2 months)  | _____ Last year's income tax return (if required to file) |
| _____ 4 most recent bank statements for each account   | _____ W-2 and 1099 forms                                  |
| _____ Proof of income that is not directly deposited (example – copy of Social Security check) |   |

With my signature I agree that this information is true and correct and that I am responsible for any unpaid balance. If any of this information should prove to be knowingly misrepresented I will repay any fees reduced by this agreement. I understand that my continuing eligibility for reduced fees will be reviewed each year.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**ELIGIBILITY DECISION**

\_\_\_\_\_ You are eligible to receive individual services at \_\_\_\_\_% of the full fee cost (minimum charge \$\_\_\_\_\_).

\_\_\_\_\_ You are eligible to receive group therapy services at \_\_\_\_\_% of the full fee cost (minimum charge \$\_\_\_\_\_).

\_\_\_\_\_ You are eligible for hearing aids at \_\_\_\_\_% of the full fee cost.

\_\_\_\_\_ Your income exceeds our guidelines.