GIFT OF HEARING

GPA GIFT OF HEARING
NOMINATION FORM

GIFT OF HEARING

Thank you for your interest in the GPA Gift of Hearing program. In order to be considered, please submit a 500 word essay about why the candidate is in need of help. In order to better understand the nominee's hearing and financial situation, please also complete the following questionnaire and send or drop off to the address at the bottom of the letter.

PATIENT NAME _____

PATIENT DATE OF BIRTH _____ AGE _____

ADDRESS _____

HOME PHONE # _____ CELL # _____

EMAIL ADDRESS _____ REFERRED BY _____

HAVE YOU EVER WORN HEARING AIDS? _____

DO YOU CURRENTLY WEAR HEARING AIDS? _____

IF YES, HOW OLD ARE THEY? _____

WHERE WERE THEY PURCHASED? _____

HAVE YOU EVER HAD A HEARING TEST? _____

WHEN AND WHERE WAS YOUR LAST HEARING TEST COMPLETED? _____

_____

INSURANCE INFORMATION Please provide some basic information about your current insurance plan. We use this information to look into if you have hearing aid benefits and if you are able to utilize them here.

ARE YOU CURRENTLY WORKING? _____

DO YOU HAVE INSURANCE? _____

IF YES, THROUGH WHO? _____

ARE YOU A VETERAN? _____

ARE YOU AFFILIATED WITH THE VA? _____

Please provide the contract number and group number from your insurance card.

CONTRACT NUMBER _____

GROUP NUMBER _____

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