HEAR Center
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Sliding Scale Application

HEAR Center, a non-profit organization since 1954, offers complete and affordable hearing and speech services, and is dedicated to helping people at all stages of life be a part of the hearing and speaking world. Discounts are offered depending upon household income and size. Please complete the following information and return to the Office Manager (Debbie Lorino) to determine if you or members of your family are eligible for a discount. Discount is good for one year, upon approval.

Sliding Scale - please indicate which service(s) you will like to apply for our sliding scale:

- Speech Therapy-$65/hour - *(without sliding scale $110 hour)*
- Speech Evaluations -$150 - *(without sliding scale $360)*
- Audiological Evaluations -$60 - *(without sliding scale $125)*
- Ear molds -$100 (1 set/2 ear molds), $50 (1 ear mold) only for standard material ear mold(s). - *(without sliding scale $100 each)*

Discount(s) apply for services indicated above, upon approval (hearing aids excluded).

Proof is required in order to qualify for our sliding scale. Please provide us with one of the following 2 options:

- ☐ Government assistance
- ☐ Income (please attach insurance denial letter if you have one)

Number of persons living in your household: _____

Total household income (complete one column)			
	Annual	**Monthly**	**Bi-Weekly**
Self			
Spouse			
Relatives			
Others			
Total			

Please provide us with either of the following to verify income:

- ☐ 1040 (first 2 pages), or
- ☐ Paystub (last paystub)

NOTE: Include income from all persons in household and income from all sources, including gross wages, tips, social security, disability, pensions, annuities, veteran's payments, net business or self-employment, alimony, child support, military, unemployment, public aid, and other.

I certify that the household size and income shown above is correct. Copies of tax return, pay stubs, and other information verifying income may be required before a discount is approved and will be provided as may be requested.

_____ _____

Name (Print) Signature Date

OFFICE USE ONLY

Patient Name: _____ Discount: ☐ Approved ☐ Not Approved

Date of Service:_____ Approved by:_____

Updated 2/04/14