**APPLICATION FOR SCHOLARSHIP FUNDING**

**PROOF OF FINANCIAL STATUS IS REQUIRED TO BE CONSIDERED FOR SCHOLARSHIP FUNDING.**

**COPIES of the following documents must be provided to the Center for Hearing & Speech:**

- Last year's federal income tax return (scratch out social security numbers)
- Report of benefits from the Social Security Administration (scratch out social security numbers)
- Most recent bank statements (scratch out account numbers)
- Most recent payroll stubs

**Complete this form and attach the required income information.**

**Mail to:** **Director of Finance**
**Center for Hearing & Speech**
**9835 Manchester Road**
**St. Louis, MO 63119**

**You will receive a phone call within 10 business days regarding your eligibility for scholarship funding.**

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If you currently have MO Healthnet (previously Missouri Medicaid) Insurance, please **DO NOT** complete this application. Please contact our office at 314-968-4710. Date:_____

Name of person in need of services _____Age:_____Birth Date:_____

Address:_____City:_____State:_____Zip:_____

Home Phone_____ Cell Phone_____ Work Phone_____

How many adults live in the household?_____ How many children live in the household?_____

Check the service for which financial assistance is requested:

[ ] Hearing Evaluation [ ] Hearing Aid [ ] Hearing Aid Repair [ ] Speech Evaluation [ ] Speech Therapy

Have you ever received a hearing aid from the Center for Hearing & Speech? [ ] Yes [ ] No
If yes, how long ago? _____

If services are requested for **a minor** (under 21 years old) **child, or a disabled adult child,** complete the following:

Parent's name(s)_____Address _____

Employer:_____Occupation_____

If services are being requested for a child, who is the legal guardian?_____

Who referred you to the Center for Hearing & Speech? _____

What is the **total household** monthly income?_____ (be sure to include social security, welfare, retirement pension, child support, alimony)

Does anyone in the household receive welfare? [ ] Yes [ ] No Receive food stamps? [ ] Yes [ ] No

Does the person in need of services from the Center have health insurance? [ ] Yes [ ] No

If yes to health insurance, what is the name of the insurance carrier? _____

List monthly medical expenses NOT covered by insurance:

$_____for medications $_____for dental work $_____for _____

Please use the space below to provide any additional information that you feel will help in the determination of the level of financial assistance that you will be awarded.

_____

_____

_____

**Remember to send this completed form in with the required proof of income listed on the front of this form.**

**If you have any questions filling out this form, please call the Center for Hearing & Speech for help.**

**314-968-4710**

**I hereby certify that to the best of my knowledge the information provided is accurate.**

_____ (Signature) _____ (Date)

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**FOR OFFICE USE ONLY:** % or amount of scholarship funding awarded: _____

Comments:_____

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