

NORTHEASTERN UNIVERSITY
Speech-Language and Hearing Center

503 Behrakis Health Sciences Center
30 Leon Street, Boston, Massachusetts 02115
Tel: 617-373-2492 FAX: 617-373-8756

The Boston Guild Hearing Aid Outreach Program at Northeastern University

Application Directions

The mission of the Boston Guild Hearing Aid Outreach Program is to offer quality hearing care and hearing aid(s) to individuals in the community who need financial assistance. This outstanding program offers hearing screenings/evaluations, consultation regarding amplification options, the selection and fitting of hearing aid(s), and complimentary training sessions that teach vital skills to improve communication for individuals with hearing loss and their families.

To apply for this program, one must complete the following requirements and steps:

1. Confirm that you do NOT have insurance that will cover amplification by signing the “Policies” form (page 2)
2. Agree to contribute the designated amount towards the hearing aid(s) by signing the “Policies” form (page 2)
3. Receive a referral from an individual in the community who can assure your financial need (i.e., your audiologist, doctor, other health care provider, social worker, or clergy) by having him/her complete the “Financial Assistance Referral” on the Application form (page 3, section 2).
4. Receive medical clearance to get amplification from an approved medical provider (i.e., Otolologist, Otolaryngologist, Physician, Physician’s Assistant, or Nurse Practitioner) by having him/her complete the “Medical Clearance for Hearing Aid(s)” on the Application form (page 3, section 3).
5. Contact the Speech-Language and Hearing Center at Northeastern University and request to be added to the waitlist for the Boston Guild Outreach Program
6. Mail the completed copies of page 2 and 3 of this application to:

Speech Language and Hearing Center, 503 Behrakis Health Sciences Center, 30 Leon Street, Boston, MA 02115.

Copies may be faxed to: 617-373-8756

Please note that ALL sections of an application must be completed in order to be processed. When an application has been approved, you will be called and an appointment will be scheduled. Please bring any recent hearing tests and reports to the appointment or have them faxed from the testing facility with your permission. If you have NOT had your hearing tested within the last six months of your appointment, let us know and you will be scheduled for a hearing evaluation along with your appointment.

Our office is located on Northeastern University’s campus at the address listed above. It is accessible by the MBTA Green Line (E train, Northeastern stop) or Orange Line (Ruggles stop). Parking is available next door in the West Village Garage provided that it has been scheduled through our office.

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POLICIES

This program offers hearing aid(s) at a reduced cost for a patient who qualifies for financial assistance. In order to be approved to participate in this program, a patient must complete and return the "Policy" and Application" forms (page 2 and 3 of this packet). **ALL** portions of both forms must be completed in order to be processed for approval. Once approved, each patient would be placed on a waiting list and would be contacted when an appointment could be scheduled.

A patient may receive financial assistance for one or two hearing aids. If a patient was interested in receiving one hearing aid, the patient would be expected to contribute \$250.00 towards the processing cost of the hearing aid. The Guild Outreach Program would pay for the majority of the cost of the hearing aid.

If a patient was interested in receiving two hearing aids, the patient would be expected to contribute \$250.00 for the first hearing aid and \$700 for the second hearing aid. The patient would pay a total of \$950 towards the processing cost of two hearing aids and the Guild Outreach Program would pay for the remainder of the cost of both hearing aids.

The Guild Outreach Program will provide follow up care for the hearing aid within the warranty period, with the exception of routine maintenance costs such as: batteries, domes, earmolds and other accessories. Once the instrument is out of warranty, the patient would be responsible for the cost of repairs, replacements, and warranty extensions. Processing fees associated with a loss or damage claim under warranty would be the responsibility of the recipient. It is our goal to work together with recipients towards successful hearing outcomes.

Please mark the following:

_____ I have read and agree with the policies of the Boston Guild Hearing Aid Outreach Program at Northeastern University.

Printed Name: _____ Signature: _____

Date: _____ Phone: _____

Street Address: _____

City: _____ State: _____ Zip Code: _____

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APPLICATION

1. APPLICANT'S INFORMATION

Name of person who needs hearing aid(s): _____

DOB: _____ Today's Date: _____

Home Phone: _____ Cell Phone: _____

Street Address: _____

City: _____ State: _____ Zip Code: _____

Contact Name and Phone if different than applicant: _____

_____ I certify that I do NOT have insurance that might cover hearing aids. **Please call your insurance company to verify that they do not cover hearing aids before submitting this application.

2. FINANCIAL ASSISTANCE REFERRAL

To the best of my knowledge, the above named individual is a person in need of financial assistance for the purchase of hearing aids.

Name of Referral Source: _____ Signature: _____

Relationship to patient: _____ Phone: _____

Street Address: _____

City: _____ State: _____ Zip Code: _____

Address: _____ City: _____ State: _____ Zip Code: _____

3. MEDICAL CLEARANCE FOR HEARING AID(S)

I have examined the above named patient and found that there is no medical contraindication to hearing aid use in: ___ left ear ___ right ear ___ both ears.

Physician's Name: _____ Signature: _____

Practice's Name: _____ Date: _____

*May be an Otologist, Otolaryngologist, Physician, Physician's Assistant, or Nurse Practitioner.