

## Application for Financial Assistance for Buffalo Hearing & Speech Center's Specialized Programs

Please complete all pages of this form and return with copies of your **latest tax return documents** (e.g. Form 1040) **and your most recent pay stub** to be considered for financial assistance. Please note completion of this form does not in any way guarantee you or your child will receive financial assistance. You will be notified as soon as possible if you are eligible for financial assistance.

**Return completed form to:** Buffalo Hearing and Speech Center  
50 East North Street  
Buffalo, NY 14203

Child's Name \_\_\_\_\_ Child's Age \_\_\_\_\_ DOB \_\_\_\_\_

Your Name \_\_\_\_\_ Relationship to Child \_\_\_\_\_

Address \_\_\_\_\_

Phone Numbers \_\_\_\_\_

Please check the box next to the program(s) in which you are applying for financial assistance:

- 1. The total cost for the **Language to Literacy Program™** is as follows:
  - Supply Kit: \$200 (includes binder, books, materials, incentive items, etc.)
  - Tuition \$1700 (equals \$85.00 per day) **or** your insurance co-pay and/or
- 2. The total cost for the **Social Communication Program™** is as follows:
  - Supply Kit: \$100 (includes binder, books, materials, incentive items, etc.)
  - Tuition \$1700 (equals \$85.00 per day) **or** your insurance co-pay and/or
- 3. The total cost for the **Leap Into Literacy Program™** is as follows:
  - Supply Kit: \$100 (includes binder, books, materials, incentive items, etc.)
  - Tuition \$1700 (equals \$85.00 per day) **or** your insurance co-pay and/or
- 4. The total cost for the **FastForward Program** is as follows:
  - Supply Kit: \$50 (includes binder, books, materials, incentive items, etc.)
  - Tuition \$3,400 **or** your insurance co-pay

What amount do you believe you can contribute? \_\_\_\_\_

1. Are you or a responsible adult able to provide transportation for your child to and from the program indicated above two or three days per week? \_\_\_\_ Yes \_\_\_\_ No
2. Present Combined Yearly Gross Salary of Primary Parents/Guardians (before taxes):  
\$ \_\_\_\_\_  
(attach copy of most recent pay stub)

Parent or Guarantor #1:

Relationship to patient:  self  child  spouse

Name: \_\_\_\_\_

Employer: \_\_\_\_\_

Insurance Coverage: \_\_\_\_\_

Major Medical Coverage: \_\_\_\_\_

Annual Gross: \_\_\_\_\_ Amount Net: \_\_\_\_\_

**Parent or Guarantor #2:**

Relationship to patient:  self  child  spouse

Name: \_\_\_\_\_

Employer: \_\_\_\_\_

Insurance Coverage: \_\_\_\_\_

Major Medical Coverage: \_\_\_\_\_

Annual Gross: \_\_\_\_\_ Amount Net: \_\_\_\_\_

**Number of Children:** at home \_\_\_\_\_ outside home \_\_\_\_\_

3. Please check the box to indicate what insurance company your child has, if any:

- Independent Health  Medisource
- Community Blue  Medicaid
- Univera  \_\_\_\_\_ + Medicaid
- Fidelis  Other \_\_\_\_\_
- Policy Number \_\_\_\_\_

4. Please check the box(es) to indicate any financial assistance you are currently receiving and list the amount of funds you receive per month:

- Medicaid: \$ \_\_\_\_\_  NYS Disability: \$ \_\_\_\_\_
- Food Stamps: \$ \_\_\_\_\_  Temporary Assistance for Needy Families (TANF): \$ \_\_\_\_\_
- Child Support: \$ \_\_\_\_\_  Alimony: \$ \_\_\_\_\_
- Unemployment: \$ \_\_\_\_\_
- Other & Monthly Amounts \_\_\_\_\_

If your child is absent for a class, the tuition for that class has not been paid. As a result, a missed session fee (\$50.00) for each class missed must be charged in order to meet tuition requirements. Missed session fee's are the responsibility of the patient and cannot be paid by your insurance company or by awarded financial assistance.

5. Please list if there any other financial hardships that affect your ability to afford this program that you feel we should know about.

\_\_\_\_\_

6. Are you willing to commit to spending 15 – 30 minutes for 3 – 4 nights per week working with your child to maximize your child's progress?

\_\_\_\_ No. List Reason(s):

\_\_\_\_ Yes. List Reason(s):

Additional Comments: \_\_\_\_\_

Thank you for applying for financial assistance to the  
Specialized Programs at Buffalo Hearing and Speech Center

By signing below, I, \_\_\_\_\_ the  
(print parent/guardian's name)  
parent/guardian of \_\_\_\_\_, understand and agree to  
(print child's name)  
the terms and conditions of this application and certify that all my answers are correct and true to the  
best of my knowledge.

\_\_\_\_\_  
Parent/Guardian Signature Date

\_\_\_\_\_  
Print Name

**For Office Use Only – Do Not Write Below this Line**

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Date Application Received: \_\_\_\_\_

Tax Return Documents Included \_\_\_\_\_

Date Reviewed \_\_\_\_\_

Application Approved for \$ \_\_\_\_\_ Scholarship

Application Denied for \_\_\_\_\_

Director's Signature \_\_\_\_\_ Date \_\_\_\_\_

CFO's Signature \_\_\_\_\_ Date \_\_\_\_\_