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Dear Applicant,

The Sertoma Speech and Hearing Centers has a limited budget to help you receive the speech and hearing services that you need. We must be considered, however, a payer of last resort. Please note the following:

- This offer is limited to legal US residents currently living in Illinois in the counties of Cook, DuPage, Will, or Grundy who are seeking services or products from Sertoma Speech and Hearing Centers.
- While we offer assistance to qualified candidates, be aware that collecting all the information you need for this application is time consuming.
- After receiving your completed application, we will review it carefully to determine your eligibility and notify you as soon as we have completed this process.

➤ To determine your eligibility for assistance, it is important to follow the **Four Steps** presented below.

Step 1

Review the master checklist below so that you understand all the items required to complete this application. *Applications without all the required documentation will be denied support.*

Master Checklist for the Professional-Services Assistance Application

- **Complete Step 1:** Review this master checklist so that you understand all the items required to complete this application. *Applications without all the required documentation will be denied support.*
- **Complete Step 2:** Provide all denials received.
- **Complete Step 3:** Only if you have been denied support in Step 2, proceed to Step 3, the application (which starts on page 4 of this document).
- **Complete Step 4:** Mail or drop-off your completed form and supporting documentation.
- Accurate information must be provided for all of the following items:
    - Applicant Information
    - Patient /Guardian / Spouse Information
    - Service Applied For
    - Employment Information
    - Monthly Income (all)
    - Personal Assets (all)
    - Allowable Financial Liabilities and Monthly Expenses
    - Sign the Certification paragraph
    - Complete Financial Statement of Guarantor(s) including signature(s)
    - Release of Information for patient care, educational, promotional and fundraising purpose (including signature(s))
    - Complete your support in our fundraising efforts
    - Complete the Equal Opportunity Reporting Form
- Gather all supporting documentation listed on the Income Verification Checklist
- Gather all supporting documentation listed on the Personal Assets Checklist
- Gather all supporting documentation listed on the Expense Verification Checklist

Income Verification Checklist

- Copy of your IL Driver's License or State ID Card
- Last 3 years of Tax Returns

Last 3 years of W-2s, SSA-1099, pension earnings, etc.

- Interest
- Alimony
- Rental Income

Personal Assets Checklist

- Last 3 months of Bank Statements (Checking & Savings)

Expense Verification Checklist

- Last 3 months of Mortgage Statements
- Last 3 months of Rent Invoices or Payments
- Last 3 months of any Loan Statements
- Last 3 months of all Credit Card Statements
- Last 3 months of Utility Bills – (including Water, Gas, Electricity, Cell Phone, Cable, etc.)
- Last 3 months of Child Care Invoices or Payments
- Last 12 months of Insurance Statements or Payments

Step 2

Your next step is to contact the organizations listed below for financial support.

- Your insurance provider. Do they cover testing or hearing instruments? Please let us know the extent of the coverage that they will provide.
- Patients from birth to 3 years of age, contact Child and Family Connections — 1-888-594-8364. To visit their website, click here.
    - Patients from birth to 18 years of age, contact the Division of Specialized Care for Children Chicago South Regional Office: 312-433-4100
    - South Cook Regional Office: 708-482-0633
    - DuPage Regional Office: 630-964-9887
    - To visit their website, click here.
- Patients older than 18, contact the Illinois Department of Human Services — 1- 800-843-6154 or, to visit their website, click here.
- Veterans, contact your local VA office. For the VA's website and facility locator, click here.

If you're denied support by these organizations, please proceed to Step 3 below.

Step 3

If you're denied support by the organizations listed in Step 2, only then fill out our Application for Professional-Services Assistance.

If you have any questions or need further assistance with any aspect of this application, please email Patricia Mulcahy or call Patricia at 708-599-9500.

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Step 4

Mail your completed application with supporting evidence to the following address:

Sertoma Speech and Hearing Centers
Professional-Services Assistance Application
10409 S Roberts Road
Palos Hills IL 60465

If you have any questions or need further assistance with any aspect of this application, please email Patricia Mulcahy or call Patricia at 708-599-9500.

The application starts on the next page…

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PROFESSIONAL-SERVICES ASSISTANCE APPLICATION

APPLICANT INFORMATION ~ PLEASE PRINT CLEARLY

Name	Date of Birth
Address	Home Phone
City, State & Zip	Other Phone

PARENT / GUARDIAN / SPOUSE INFORMATION

Mother / Guardian	Father /Guardian
Address	Address
City, State & Zip	City, State & Zip

SERVICES APPLIED FOR

Type of Service (check box below)
❑ Hearing Evaluation, $250
❑ Hearing Instrument, $1,720
❑ Speech Evaluation, $250
❑ Speech-Language Therapy, $110 (one hour)
❑ Speech-Language Therapy, $65 (half hour)

EMPLOYMENT INFORMATION

Employer	Employer
Address	Address
Phone	Phone
Position	Position

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MONTHLY INCOME

Gross Monthly Salary	$
Child Support	$
Commissions	$
Shared Living	$
Disability	$
Stocks, Bonds, Annuities	$
Pension	$
Rental Income	$
Alimony	$
Interest	$
TOTAL MONTHLY INCOME	$

NOTE: Verification of income must accompany this application (such as IRS Tax Return, pay stubs or income verification from employer.

PERSONAL ASSETS

Banking			
Checking Account Balance	$		
Saving Account Balance	$		
House			
Mortgage Balance	$		
Estimated Value of House	$		
Automobiles			
Year	**Make**	**Model**	**Estimated Value**
			$
			$
			$

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ALLOWABLE FINANCIAL LIABILITIES AND MONTHLY EXPENSES

Expense Category	Amount / Balance
House / Apartment	$
Car / Transportation	$
Medical / Dental	$
Loans (not credit card)	$
Credit Card	$
Utilities	$
Child Care	$
Insurances	$
Groceries	$
TOTAL MONTHLY EXPENSES	$

CERTIFICATION

In accordance with Illinois law (720 ILCS 5/17-3), I understand that it is a crime to deceive a charitable organization for the purpose of obtaining goods or services. Accordingly, I certify that the information contained in this financial review and assistance request is true to the best of my knowledge. I further understand that Sertoma Speech and Hearing Centers may verify any of the above information and I grant my permission for such verification and agree to assist in any way requested. I understand that the Sertoma Speech and Hearing Centers reserves the right to cancel my assistance and collect full fees for services in the event of fraudulent-financial status while involved with any of the programs. Moreover, I understand that regular reviews of my financial status will be conducted at the discretion of the Sertoma Speech and Hearing Centers.

_____ _____

Signature (Patient / Guardian) Date

PLEASE MAIL OR DROP OFF YOUR COMPLETED FORM TO THE FOLLOWING ADDRESS:

SERTOMA SPEECH & HEARING CENTERS
10409 S ROBERTS ROAD
PALOS HILLS IL 60465

IF YOU HAVE ANY QUESTIONS, PLEASE CALL 708-599-9500.

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PERSONAL FINANCIAL STATEMENT OF GUARANTOR(S)

Patient name: _____

I, _____, certify that my gross household income (before taxes) has been $ _____ for the past 12 months and that there are _____ number of people in my household.

I understand that the income information I have provided may be verified by Sertoma Speech & Hearing Centers.

The out-of-pocket expenses for the above named patient have totaled $ _____ for the past 12 months (documentation is required for this).

I understand that in accordance with the Illinois law (720 ILCS 5/17-3), it is a crime to deceive a charitable organization for the purpose of obtaining goods or services.

Guarantor: _____ Date: _____

Witness: _____ Date: _____

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RELEASE OF INFORMATION FOR PATIENT CARE, EDUCATIONAL, PROMOTIONAL, AND FUNDRAISING PURPOSES

I understand that release of information regarding my care and treatment may be used for patient care, educational, promotional, public relations and/or fund-raising purposes. I have been asked by SERTOMA SPEECH & HEARING CENTERS for permission to use any and all records of my care and treatment, which may be used for these purposes.

I further understand that photographs, movies or video tapes may be taken of my care and treatment and authorize the use of said photographs, movies or video tapes for the purposes of patient care, education, promotion, public relations and/or fund-raising.

I hereby understand that information regarding my care and treatment and the photographs, movies, and videotapes taken of my care and treatment may be used by SERTOMA SPEECH & HEARING Centers in promotional materials and for publicity.

I hereby authorize SERTOMA SPEECH & HEARING CENTERS to utilize my records, photographs, movies, or videotapes for publicity purposes and further authorize the same to publish all or portions of said records, photographs, movies, and videotapes for said purposes. I authorize, for purposes of publicity, release of my name and information regarding care and treatment.

I further understand that SERTOMA SPEECH & HEARING CENTERS in releasing this information for the purposes set forth above shall have NO responsibility of liability for the use of said information by SERTOMA SPEECH & HEARING CENTERS, its staff or others and exonerate the SERTOMA SPEECH & HEARING CENTERS of any and all liability or claim that might arise in understanding any filming or in the use of the records, photographs, movies, or video tapes of myself.

I agree to all of the above.

Patient/Guardian: _____

Witness: _____

Dated this _____ **day of** _____**, 20**_____

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May we count on your support in our fundraising efforts to help children and adults who need speech and hearing health care but cannot afford it currently?

We frequently need volunteers to help us with projects we conduct throughout the year to fulfill our nonprofit outreach mission of providing communication health care to those in need regardless of their ability to pay.

Name _____

Address _____

City _____ State _____ Zip _____

Phone _____ Email _____

I can devote _____ hours/months to assist Sertoma Speech & Hearing Centers in the following way(s). Please check all the categories that interest you.

- ❏ Special events
- ❏ Mailings
- ❏ Health fairs
- ❏ Database entry
- ❏ Other (please describe)

Thank you for helping us fulfill our nonprofit, outreach mission of helping those who need speech and hearing health care in Northern Illinois, Northern Indiana, and Southern Wisconsin.

Michelle Morrison, Ed.D.
Executive Director

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EQUAL OPPORTUNITY REPORTING FORM

The information requested on this form is used for government reporting only and is confidential. Please provide all the information that pertains to you.

Patient Name (print)	
Date of Birth (print)	
Sex (check box)	❑ Male ❑ Female
Ethnic Group/Race	**Please check the category that applies to you below.**
❑ White	Note of Hispanic origin. All persons having origins in any of the original peoples of Europe, North Africa, or the Middle East.
❑ Black	Not of Hispanic origin. All persons having origins in any of the Black racial groups of Africa.
❑ Hispanic	All persons of Mexican, Puerto Rican, Cuban, Central or South America, or other Spanish culture of origin, regardless of race.
❑ Asian or Pacific Islander	All persons having origins in any of the original peoples of the Far East, Southeast Asia, the Indian Subcontinent, or the Pacific Islands. This area includes, for example, China, Japan, Korea, Philippine Islands, and Samoa.
❑ American Indian or Alaska Native	All persons having origins in any of the original peoples of North America and who maintain cultural identification through tribal affiliation or community recognition.