SERTOMA Club of Springfield, IL

Hearing Aid Request Program (S.H.A.R.P.)

Please Print (Information is Confidential)

Name_____

Address_____City_____Zip_____

Phone_____Age_____ Marital Status_____

Own home_____Rent_____Other (describe)_____

Number of Persons in Household_____Dependents_____Ages_____

Total Household Annual Income_____Employed?_____

Do you receive: Medicaid_____Medicare_____

Health Insurance Co._____Group ID#_____ID#_____

Note: Medicaid, Veterans Admin, and private insurance may pay/assist with the cost of a hearing aid. If you might qualify, please check with them PRIOR to making this application. Those benefits CANNOT be combined with Sertoma.

PLEASE ATTACH A COPY OF YOUR MOST RECENT INCOME TAX FORMS OR PROOF OF INCOME

Signature_____Date_____

Mail completed application and tax form to: SERTOMA Club of Springfield,

P. O. Box 2471, Springfield, IL 62705-2471

_____

Date Received_____Date approved_____

Rev. 2/25