Upon completion, please do one of the following:

Email to: clinic@familyhearinghelp.org
Fax to: 727-807-6172
Mail to:
Sertoma Speech & Hearing Foundation
5211 US Hwy 19, Ste 200
New Port Richey, FL 34652

Referral Source: _____

Phone No. _____

SERTOMA SPEECH & HEARING FOUNDATION OF FLORIDA, INC.
APPLICATION FOR FINANCIAL ASSISTANCE

PATIENT INFORMATION: PLEASE PRINT

Name: _____ Date of Birth: _____ Age: _____

Address: _____ Home Phone: _____

City: _____ Zip: _____ Alternate Phone: _____

Email: _____

PARENT / GUARDIAN / SPOUSE INFORMATION

Spouse / Parent: _____ Parent / Guardian: _____

Address: _____ Address: _____

City: _____ Zip: _____ City: _____ Zip: _____

FINANCIAL INFORMATION

Employer: _____ Employer: _____

Address: _____ Address: _____

Phone: _____ Phone: _____

Position: _____ Position: _____

HOME AND ASSETS

Gross Monthly Income: $_____ Gross Monthly Income: $_____

OTHER INCOME

Child Support: $_____ Pension: $_____

Commissions: $_____ Rental Income: $_____

Shared Living: $_____ Alimony: $_____

Disability: $_____ Interest: $_____

Stocks, Bonds, Annuities: $_____ Other: $_____

All applicants must provide verification of any and all income. Most applicants will provide a copy of their most recently filed tax return or current year social security benefits statement. If you do not have either of these documents, please call our office at 727-312-3881 or email clinic@familyhearinghelp.org before submitting this application.

If submitting electronically, submit your income verification here:

PERSONAL FINANCIAL STATEMENT OF GUARANTOR (S)

Patient Name: _____
Last First Initial

I, _____ certify that my gross household income (before taxes)

has been $ _____ for the past twelve (12) months and that there are

_____(#) people in my household.

I understand that the income information I have provided may be verified by:

Sertoma Speech & Hearing Foundation of Florida, Inc.

**Documentation is required

I understand that in accordance with Florida Statutes 817.50, providing false information to defraud a hospital for the purpose of obtaining goods or services, is a misdemeanor in the second degree.

Patient/Guardian _____ Date: _____

CERTIFICATION

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 the Foundation 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 Foundation 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. I understand that comparison reviews will be conducted regularly at the discretion of the Foundation.

_____ _____
Signature (Patient / Guardian) Date

SERTOMA SPEECH & HEARING FOUNDATION OF FLORIDA, INC.

May we count on your support in our fundraising efforts to help children and adults who are hearing impaired?

We are always recruiting volunteers to help us in our many projects throughout the year so that we can continue our mission to provide quality developmental and rehabilitative services, products and education (primarily to children) throughout Florida, in a caring and compassionate environment, never limited by the ability to pay.

Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone: _____ Email: _____

I can devote _____hours to assist Sertoma Speech & Hearing Foundation in the following way:

Special Events _____

Home Projects _____

Mailings _____

Hearing Screenings _____

Other _____

Thank you for your support in keeping the vision and mission of Sertoma Speech & Hearing Foundation moving forward.

Debra Golinski
Executive Director

SERTOMA
Speech & Hearing
Foundation
of Florida, Inc.

EQUAL OPPORTUNITY REPORTING FORM

The information requested on this form is used for government reporting purposes only and is confidential. Please complete the appropriate boxes that pertain to you.

Patient Name: _____ **Date of Birth**: _____

Social Security Number: _____/_____/_____

Sex: ☐ Male ☐ Female

ETHNIC GROUP/RACE

☐ **White** (Not 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, the Philippine Islands, and Samoa.

☐ **American Indian or Alaskan 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.

SERTOMA SPEECH & HEARING FOUNDATION OF FLORIDA, INC. RELEASE OF INFORMATION FOR PATIENT CARE, EDUCATIONAL, PROMOTIONAL, AND FUNDRAISING PURPOSES

FOR PEDIATRIC PATIENTS

I (we) understand that release of information regarding my (our) child's care and treatment may assist others on training, education, or research. We have been asked by **SERTOMA SPEECH & HEARING FOUNDATION OF FLORIDA, INC.** for permission to use any and all records of my (our) child's care and treatment that may be used for patient care purposes, in training, education, and research.

I (we) further understand that photographs, movies, or video tapes may be taken of my (our) child's care and treatment and authorize the use of said photographs, movies, or video tapes for the purposes of training, education, and research provided that no disclosure of my (our) name or my (our) child's name be in any presentation or publication.

I (we) hereby understand that information regarding my (our) child's care and treatment and the photographs, movies, and videotapes taken of my (our) child's care and treatment may be used by **SERTOMA SPEECH & HEARING FOUNDATION OF FLORIDA, INC.** in promotional materials and for publicity.

I (we) hereby authorize **SERTOMA SPEECH & HEARING FOUNDATION OF FLORIDA, INC.** to utilize my (our) child's 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 (we) authorize, for purposes of publicity, release of my (our) child's name and information regarding care and treatment.

I (we) further understand that **SERTOMA SPEECH & HEARING FOUNDATION OF FLORIDA, INC.** 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 FOUNDATION OF FLORIDA, INC.** from any and all liability or claim that might arise in understanding any filming or in the use of the records, photographs, movies, or videotapes of my (our) child, _____

(print child's first and last name)

I AGREE TO ALL OF THE ABOVE

Dated this _____ day of _____, 20____

_____ _____

Parent/Guardian Printed Name **Parent/Guardian Signature**

SERTOMA SPEECH & HEARING FOUNDATION OF FLORIDA, INC. RELEASE OF INFORMATION FOR PATIENT CARE, EDUCATIONAL, PROMOTIONAL, AND FUNDRAISING PURPOSES

FOR ADULT PATIENTS

I understand that release of information regarding my care and treatment may assist others on training, education, or research. We have been asked by **SERTOMA SPEECH & HEARING FOUNDATION OF FLORIDA, INC.** for permission to use any and all records of my care and treatment that may be used for patient care purposes, in training, education, and research.

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 training, education, and research provided that no disclosure of my name be in any presentation or publication.

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 FOUNDATION OF FLORIDA, INC.** in promotional materials and for publicity.

I hereby authorize **SERTOMA SPEECH & HEARING FOUNDATION OF FLORIDA, INC.** 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 FOUNDATION OF FLORIDA, INC.** 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 FOUNDATION OF FLORIDA, INC.** from any and all liability or claim that might arise in understanding any filming or in the use of the records, photographs, movies, or videotapes of me, _____

(print patient's first and last name)

I AGREE TO ALL OF THE ABOVE

Dated this _____ day of _____, 20____

_____ _____

Patient Printed Name **Patient Signature**

PATIENT AUTHORIZATION FORM

Authorization to release patient records to individuals.

Many of our patients allow family members such as their spouse, significant other, parents, or children to call and request the result of tests, procedures, and financial information. Under the requirements of HIPAA, we are not allowed to provide any patient information to anyone without the patient's consent. If you wish to have your medical and/or financial information released to any individual, you must complete and sign this form.

You have the right to revoke this consent, in writing, except where we have already made disclosures in reliance on your prior consent. I authorize Sertoma Speech & Hearing Foundation of Florida, Inc. (Sertoma), to release my records and any requested information to the below individuals:

1. _____ Relationship to Patient: _____
2. _____ Relationship to Patient: _____
3. _____ Relationship to Patient: _____
4. _____ Relationship to Patient: _____

Additionally, I authorize Sertoma to release information regarding my share of cost for services to the following individual(s), group(s), or individual(s) associated with the below group(s):

_____

Authorization Regarding Messages

(please check all that apply)

☐ I authorize Sertoma to leave a detailed message on the below phone number regarding appointments.

☐ I authorize Sertoma to leave a detailed message on my below phone number regarding medical treatment, care, test results, or financial information.

☐ I authorize Sertoma to leave a message with anyone who answers the below phone.

☐ I authorize Sertoma to text the number below with information regarding patient care.

☐ Sertoma may only leave messages on the below phone number with the following person(s):

_____

Authorized phone number(s): _____

Printed patient name: _____

Patient/Legal Guardian Signature: _____ Date:

Print Name: _____