



PARENT & INFANT FINANCIAL AID PROGRAM—2019

Overview

The Parent & Infant Financial Aid Program provides financial aid to families of infants and toddlers ages birth through 3 who have been diagnosed with a moderately-severe to profound hearing loss, who are in pursuit of a spoken language outcome for their child. Grants are awarded to assist with expenses associated with obtaining services such as auditory support services, speech-language therapy, technology, pre-school fees/tuition, etc. Families should be committed to a listening and spoken language approach for their child's listening, speech, oral communication and cognitive skills.

These awards are made one time for the year, generally in the month of December. Award recipients may apply for this program again in future years. Award amounts vary; over the past three years, awards have ranged from \$300 to \$2,000.

Eligibility Criteria

In order to be eligible for this program, applicants must meet all of the following criteria:

- The child's fourth birthday must be **after** December 31, 2019.
- The child must have a documented bilateral hearing loss or auditory neuropathy.
Note: Children with unilateral (one-sided) hearing loss or unilateral auditory neuropathy do not qualify.
- The child's hearing loss must be within the moderately-severe to profound range. *Children with cochlear implants meet this eligibility requirement.* The child must have an unaided Pure-Tone Average (PTA) of 55dB or greater in the better hearing ear in the speech frequencies of 500, 1000, 2000 and 4000 Hz.*
**This may not apply for children who have been diagnosed with Auditory Neuropathy. For information on required documentation for AN, please see the "documentation" section on the next page.*

Formula for calculating the PTA:

On the unaided audiogram, look at the results for the better hearing ear at 500, 1000, 2000 and 4000 Hz and add those four numbers together, then divide that total by four. The result is the Pure Tone Average. To be eligible for this award, the child's PTA must be 55dB or greater.

- Parents must be committed to and pursuing a listening and spoken language outcome for the child.
- The child and family must reside in the United States (including territories) or in Canada; if in the United States, parents must provide a Social Security or Tax ID number.
- Parents/guardians should be able to clearly outline their need for financial assistance and plans for using grant funds.

NOTE: All applicants will be given a free nonprofessional membership to AG Bell.

Application Submission Instructions

Please use the following checklist to help ensure that your application is complete:

- **To Submit Electronically:** The application can be completed as a writable pdf. Please download the application and save it; enter the information into the application; and save it again. Once you have completed the application, print and scan it with the required attachments. Submit all pages **together in one document** via email to: financialaid@agbell.org.
- **To Submit by Mail:** If you choose to submit your application in paper form, all pages of the application and supporting materials should be submitted on 8½" x 11" paper (*or Canadian equivalent*).
- All pages must be single-sided; information on the back of a page will not be transmitted to the committee.
- Please remove all staples from the application.
- The application should be submitted flat (NOT folded) in a 9"x12" envelope, held together with one paper clip.

Whether you submit your application by e-mail or on paper, the application and attachments must be in English and in the following order:

- Complete single-sided application, with pages in order. *Every page of the application must be completed and the application must be signed.*
- Documentation of hearing loss.
 - **For infants and toddlers who use hearing aids** – you must include an unaided audiogram performed within the last 12 months. If your child is younger than 1 year of age and has not yet had an unaided audiogram performed, you must include a copy of the ABR (and the OAE, if performed) along with the report from the audiologist diagnosing the hearing loss in the moderate to profound range. Please Note: failure to include this information will render your application incomplete. No exceptions will be made.
 - **For infants and toddlers with a cochlear implant** – You must include the most recent programming report. If your child uses a cochlear implant and a hearing aid, only a CI programming report is required. In the absence of programming report, an appropriately marked audiogram will suffice. Please Note: failure to include a programming report or audiogram will render your application incomplete. No exceptions will be made.
 - **For infants and toddlers who have been diagnosed with Auditory Neuropathy and who do not have a cochlear implant** – You must include an unaided audiogram performed within the last 12 months and a report from the audiologist diagnosing AN with recommendations. If an audiogram is not available, you must include a copy of the ABR (and the OAE if available) along with the report from the audiologist diagnosing AN with recommendations. Please Note: failure to include this information will render your application incomplete. No exceptions will be made.
- Letter of recommendation from a hearing health or therapeutic professional (maximum of two pages, single-sided). **PLEASE NOTE: This is separate from the audiogram or CI programming report; an audiological report or evaluation is NOT a letter of recommendation.**
- Letter of recommendation from a current AG Bell member (maximum of two pages, single-sided). If you do not know an AG Bell member, please provide a recommendation from a member of your child's educational/therapeutic team.

PARENT & INFANT FINANCIAL AID APPLICATION—2019

Identifying Information

(Please print clearly in English and review for accuracy; an illegible or incorrect address will delay or possibly negate any award.)

Applicant (child) Name: _____
(First) (M.I.) (Last)

Child's Date of Birth: _____ Age as of 12/31/2019: _____ Gender: Male Female
(month/day/year)

Unaided Pure Tone Average in the better-hearing ear: _____ *(CI users please indicate "CI")*

Hearing aid users must provide an answer to this question.

The PTA in the better-hearing ear must be at least 55dB to qualify for this program.

Parent/Legal Guardian Name: _____ Occupation: _____
(First) (Last)

Relationship to child: Father Mother Legal Guardian

Mailing Address – Street: _____
City _____ State _____ Zip Code _____
(Correspondence must be addressed to a parent or legal guardian; addresses in care of another individual are not acceptable)

Email Address: _____
An email address is required for us to notify you of the status of your application. If you do not have an email address, you may provide the email address of a friend, family member, or professional who is willing to help.

Phone Number (in case we need to reach you and your email is not working): _____

APPLICANT'S HEARING HEALTH INFORMATION

Age of child when hearing loss was diagnosed: _____

If applicable, age at which he or she was fitted with hearing aid(s): _____

Does the applicant have a cochlear implant? Yes No How many? _____

If yes, age at which he or she received the cochlear implant: _____

What method(s) of communication is used with your child at home and in therapy? *Check all that apply.*

- Listening and Spoken Language
- Sign Language System (ASL, Signed English, Finger Spelling, etc.)
- Cued Speech
- Other, please briefly describe: _____

Please tell us where your child receives auditory/speech-language services: _____

Check all of the service(s) below that best describe what your child is receiving or will receive in the coming year and complete the information to the right of each selection.

	Total amount paid by family
<input type="checkbox"/> Auditory/Speech-Language Services	\$ _____
<input type="checkbox"/> Physical Therapy	\$ _____
<input type="checkbox"/> Occupational Therapy	\$ _____
<input type="checkbox"/> Parent/Family Training	\$ _____
<input type="checkbox"/> Hearing Aids Purchase	\$ _____
<input type="checkbox"/> Hearing Aid Maintenance	\$ _____
<input type="checkbox"/> Cochlear Implant initial procedure	\$ _____
<input type="checkbox"/> Cochlear Implant programming	\$ _____
<input type="checkbox"/> Other Auditory Devices such as FM Systems, Assistive Listening Devices, etc.	\$ _____
<input type="checkbox"/> Transportation Costs	\$ _____
<input type="checkbox"/> Mainstream Preschool Program	\$ _____
<input type="checkbox"/> Private Preschool Program	\$ _____
<input type="checkbox"/> Specialized Preschool Program	\$ _____
<input type="checkbox"/> Other (please describe): _____	\$ _____

Total number of dependents in your household, including the applicant: _____

Does the applicant receive support from Medicaid or SSI? Yes No

Please check your total annual gross household range of income:

- | | | |
|--|--|--|
| <input type="checkbox"/> \$20,000 or less | <input type="checkbox"/> \$40,001– \$60,000 | <input type="checkbox"/> \$80,001 – \$99,999 |
| <input type="checkbox"/> \$20,001 – \$40,000 | <input type="checkbox"/> \$60,001 – \$80,000 | <input type="checkbox"/> \$100,000 or more |

Essay Questions for Parents/Guardians

Your responses must be in English; they may be typed or written clearly and should be limited to the space provided. Please do not attach a separate sheet of paper.

Describe your family situation. Who lives in your home? How do you support your child’s development of listening and spoken language?

Briefly describe one of your child's accomplishments of which you are most proud.

If you receive an award, how will your family use it?

If your child is attending a preschool program, please indicate:

Name and location of preschool - _____

In English, briefly tell us about your child's preschool program or other educational environs, focusing on the things you feel are most beneficial for your child. *Please do not attach a brochure about the program; we want to hear about it in your words.*

Is there anything else you would to tell us?

Permission for Contact

From time to time, AG Bell may wish to contact your family as a follow up and to hear about the progress your child has made. AG Bell may also wish to feature your child and/or your family in an article for AG Bell’s award-winning magazine, *Volta Voices*, or on the AG Bell website or for a special media story. On occasion, there may be legislative action or other activity taking place in your region, and we may want to contact you to enlist your assistance.

Please indicate your preference:

- Yes, I would be happy for an AG Bell staff member to contact me in the future
- No, I prefer not to be contacted

Agreement

I certify that I am the parent or legal guardian of _____ and that, to the best of my knowledge, all information contained in this application is true and accurate. I understand that if my child is selected to receive an award, AG Bell may release general information stating this fact to the media and/or to AG Bell constituents.

Parent or Legal Guardian Signature _____

Date: _____

Child's Name: _____

NOTICE

If you live in the United States or its territories and you are selected to receive an award, the award money may be considered taxable income to you. Awards may also impact your income level for SSI. To determine this, we recommend that you consult your accountant, tax attorney, or your tax preparer.

If you live in the US or its territories and are selected to receive an award, the United States Federal Government requires that we collect a tax identification or social security number before we can process a check.* Please provide this and other required information below.

AG Bell treats this information with the strictest of confidence; it will be used only to file a 1099 with the Internal Revenue Service for total grants to you from AG Bell of \$600 or more in a calendar year. The review committee will not receive this page of your application.

Parent/Guardian Name: _____
(This is the person to whom the check will be payable and must be the same parent/legal guardian listed on page one of the application.)

Mailing Address: _____

Tax ID or Social Security Number for Parent/Legal Guardian: _____

*Please note: If you reside in the United States and cannot provide a social security or tax identification number, your application cannot be considered for an award. We apologize for any inconvenience; this is a requirement of the United States Federal Government and no exceptions will be made.



PARENT & INFANT FINANCIAL AID RECOMMENDATION—2019

You are receiving this recommendation form on the behalf of _____ who is an applicant for Parent & Infant Financial Aid for 2019. The applicant must meet all of the following criteria to be considered for the Parent-Infant award:

- The child must be under age 4 on December 31, 2019.
- The child must have a documented bilateral hearing loss or bilateral auditory neuropathy. *Children with unilateral (one-sided) hearing loss or unilateral auditory neuropathy do not qualify.*
- Hearing loss must be within the moderately-severe to profound range. This means that applicants must have an unaided Pure-Tone Average (PTA) of 55dB or greater in the better hearing ear in the speech frequencies of 500, 1000, 2000 and 4000 Hz. *Children with cochlear implants meet this eligibility requirement. Children with an AN diagnosis do not need to meet this criterion.*
- The parents must be committed to and pursuing a listening and spoken language outcome for the child.
- The child must reside in the United States (including territories) or in Canada.
- Parents/guardians should be able to clearly outline their need for financial assistance and plans for usage of grant funds.

In a letter – a maximum of two single-sided pages – preferably on your business or organization’s letterhead, please tell us the following:

- How you came to know the applicant and family and how long you have known them.
- To the best of your ability, describe the child’s method(s) of communication in his or her daily communications and educational environs (i.e. spoken language, speech reading, American Sign Language/finger spelling, cued speech, use of residual hearing, oral and/or sign language interpreters).
- Briefly share what you know about the educational progress of the child, including preschool activities, if any.
- Other observations or thoughts you have about the parents/family.
- Why you believe this applicant’s family should be considered for a Parent & Infant Financial Aid award.
- Please indicate whether or not you are an AG Bell member.

Your recommendation is required for the applicant’s application to be complete.

Please return your letter of recommendation to the applicant’s family as quickly as possible so that the family is not disqualified due to a late application.

Your recommendation may NOT be mailed or faxed separately to AG Bell.