Mississippi Health Care Foundation
Medical & Personal Needs
Grant Application - Hearing Aids

This form is to be used when submitting a funding request for hearing aids for an individual resident at a Mississippi-licensed skilled nursing care facility. **Please answer each question with as much detail as possible.** If additional space is needed, please use additional pages, noting to which question or section the extended answer belongs.

Resident Name: _____

Resident Age: _____ Resident Gender: _____

Admit Date to Facility: _____ Expected Date of Discharge: _____

Resident considered: Short-term stay _____ Long-term stay _____

Resident Primary Pay Source at Facility: _____

Facility Name: _____

Facility: _____

Facility Mailing Address: _____

Facility City/State/Zip: _____

Facility Phone Number: _____ Facility Fax Number: _____

Contact Email Address: _____

Type of Hearing Aid Being Requested: _____

This application must have the signature of the Facility Administrator and at least one other facility staff member (must be Social Work Director, Activity Director, or Director of Nursing or other appropriate staff).

Administrator's Signature: _____

Secondary Signature & Title: _____

Mail to:

Mississippi Health Care Foundation
303 Brame Road
Ridgeland, MS 39157

Or fax to: 601-898-8341

For Foundation Office Use Only

_____ Date Received _____ Date Reviewed A B C Circle Review Method

_____ Approved _____ Not Approved Approved $_____

_____ Notification Sent _____ Check Sent Check #_____

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Please be sure each question is answered with as much detail as possible before submitting application,
Use additional pages if more space is needed and identify the question being addressed.

1. Has the resident used any kind of hearing device, such as amplifier, hearing aid, etc.? ____yes _____no

2. If yes, when was the last time the resident used a hearing device? _____

3. If this is a request for an initial hearing aid, please explain if other options, such as an amplifier, have been tried and the reason why this did not work.

_____

_____

4. If another option, such as an amplifier, has not been tried, please explain why this is not an option for the resident.

_____

_____

5. If the request is for a hearing aid that is not an external hearing aid, explain why an external hearing aid cannot be used by this resident.

_____

_____

6. If the request is to replace a hearing aid, explain why the hearing aid needs to be replaced.

_____

_____

7. If the hearing aid has been lost or broken, give a detailed description of how the hearing aid was lost/broken and if lost, explain what had been done to try to find the hearing aid. (Please review page 4 regarding loss/breakage of hearing aid.)

_____

_____

8. How will the resident benefit from having a hearing aid?

_____

_____

9. Describe the resident's current physical condition, health status, and mental status.
Physical condition: _____

_____

Health status: _____

_____

Mental status: _____

_____

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10. Does the resident have any available resources that may possibly be used to assist with the purchase of hearing aid? (Attach copy of residents account to show account balance.)

_____

12. What resources does the family have to assist with the purchase of hearing aid?

_____

13. What resources are available at your facility or what is your facility doing that may be contributing to meet the resident's need?

_____

14. Describe other resources, if any, that have been explored. If funding was sought from other resources, explain why such funding was not granted.

_____

15. Why is this request being made to MHCF?

_____

_____

Attach any comments from nursing, therapy or others about why this request is being made for the resident and why they think it would be of benefit to the resident

Attach written estimate of the cost of hearing aid from the potential vendor. *

***If hearing aids for both ears cost more than $2,120.00, attach quotes from at least 2 providers.**
If a hearing aid for one ear costs more than $1,110.00, attach quotes from at least 2 providers.

Completed applications should be mailed to:
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303 Brame Road
Ridgeland, MS 39157

Or fax to: 601-898-8341

Please be sure each question was answered with as much detail as possible. Incomplete applications will be returned to the facility. MCHF reserves the right to request additional documentation and/or information.

Applications received by the 10th of the month will be reviewed for notification to the facility by the 10th of the following month. Applications received after the 10th of the month will be held for the next review period. It is estimated that it will take 3-4 weeks for review and notification to the facility.

If you have questions or need additional information, please contact MHCF at 601-898-8320.

Mississippi Health Care Foundation
Policy re: Lost/Broken Items

The Mississippi Health Care Foundation receives frequent requests to replace items that are lost or broken in the nursing home. It is the general policy of the Foundation that the replacement of items lost in the facility is the responsibility of the facility. The general policy for broken items is that this is also a facility responsibility unless justification can be provided that the item is broken due to age, normal usage by the resident, etc.

If the item was purchased by the Foundation and lost or broken within 12 months of the date of purchase, the Foundation will not consider replacing the item. If it has been more than 12 months, the policy in the above paragraph will be applied.