Application for Red Card Assistance (RCA) Funding

To apply for financial assistance, please complete the information below. Proof of active Medicaid coverage is required to be considered for this assistance. If you qualify for the RCA program, your fees will be greatly reduced.

Medicaid will not pay for the services.

Date: ______________________

Name: ____ Birth Date: ____________________

Address: ____ City: ______________________ State: ________ Zip: ____________

Home Phone: ____________________________________ Mobile Phone: ____

Medicaid #: ______________________________________ Email: ____

Household income per month: $ _________________________________ Number in household: ________________________

Have you received a hearing aid from the Center for Hearing & Speech before? YES ☐ NO ☐

If you answered YES, when did you get the hearing aid? ____

How did you hear about the Center for Hearing & Speech? ____

FOR OFFICE USE ONLY:

Verified monthly income: _____________________________________ Reviewed by: ________________________________

Approval: ____ APPROVED ☐ DENIED ☐

Medicaid verified YES ☐ NO ☐ Date: ______________________

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