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

This form is to be used with the grant application information sheet 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: _____________________________

Resident Primary Pay Source at Facility: ____

Facility: ____

Facility Mailing Address: ____

Facility City/State/Zip: ____

Facility Phone Number: ______________________ Facility Fax Number: _________________________

Type of Hearing Aid Being Requested: ____

How long has the resident had hearing loss or when was the last time the resident wore a hearing aid?

____

Has an amplification device been tried? ______ yes ______ no (see Information Sheet)

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: ____

On facility letter head, attach a 150 word minimum typed narrative with information requested on grant application information sheet. **Mail to:**

Mississippi Health Care Foundation
1076 Highland Colony Parkway
Suite 125
Ridgeland, MS 39157
Or fax to: 601-977-0273

For Foundation Office Use Only

________ Date Received _________ Date Reviewed A B C Circle Review Method

________ Approved _________ Not Approved Approved $______________

________ Notification Sent _________ Check Sent Check #________________

02/2010

Mississippi Health Care Foundation Medical/Personal Needs Grant Application - Hearing Aids Information Sheet

I. Complete Grant Application form

II. On facility letterhead, attach to Grant Application form a minimum 150 word typed narrative which includes:

- Specify the need of resident
- Explain the specific benefit to the resident
- Describe the resident's current physical condition, health status, and mental status
- Attach confirmation from an audiologist or ENT that the resident is a candidate for a hearing aid(s)
- Include 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
- Explain why the request is being made to MHCF – include whether or not an amplification device* was tried. If not, explain why this was not tried. If yes, explain why a hearing aid is being requested.
- Provide information about the type of hearing aid being requested and why that type
- If the hearing aid(s) have been lost or broken, give a detailed description of how the hearing aid(s) were lost/broken and if lost, what has been done to try to find the hearing aid(s)
- Describe resources at your facility to help meet need and/or what your facility may be contributing to meet the resident's need
- If funding has been sought from other sources, explain why such funding was not granted
- Provide information regarding the amount in the resident's trust fund and/or personal checking account and if any (even a small amount) can be used to assist with the purchase
- Describe other resources, if any, explored

*You can contact staff at Mississippi Health Care Foundation for amplification device resources.

III. Include with application:

- When and where you plan to purchase the requested item(s)
- Written estimate of the cost of each item from the potential vendor **
- Any applicable orders for the item(s) requested

**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:
Mississippi Health Care Foundation
1076 Highland Colony Parkway
600 Concourse Building, Suite 125
Ridgeland, MS 39157
Fax: 601-977-0273

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 Melzana Fuller, MHCF, at 601-956-3472.

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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 lost/broken items is the responsibility of the facility. If the facility can provide information that it is not in a position to replace the lost/broken item, and if the resident's quality of life will be reduced because of this, the Foundation will accept a request to replace the item. For items less than $2,000, the request must be approved by 4 of the 5 Review Committee members and for items over $2,000, the request must be approved by 8 of the 9 Board members.

If the item was purchased by the Foundation and lost or broken within 12 months of the date or 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 applies.