Phone 636.724.2227 ● Fax 636.724.2457
support@tpahq.org
www.tpahq.org/tpa-hearing-trust

2041 Exchange Drive
Saint Charles, Missouri
63303-5987

GENERAL GUIDELINES OF THE TPA HEARING TRUST

The TPA Hearing Trust ("Trust") operates under Section 501(c)(3) of the Internal Revenue Code. As such, the Trust must comply with all rules regarding the issuance of grants by Section 501(c)(3) organizations.

The charitable objects and purposes of this Trust are the provision of financial aid including grants to citizens of the United States, who suffer deafness or hearing loss; who will benefit from medical, mechanical, specialized treatment or specialized education and who are unable to provide the funds therefore themselves.

The funds necessary to offer such grants and aid shall be obtained from tax deductible gifts, bequests and devises obtained from individuals, firms, trusts, corporations, other entities and from accretions of investments to the Trust funds.

Applications for charitable assistance must be submitted on the approved Trust application form by adults or if a minor, by the person having legal custody of such minor.

Trust applications shall be submitted to the Board of Trustees. The selection of recipients of Trust assistance including grants and the amount thereof shall be within the sole discretion of the Board of Trustees.

The selection and amount of financial aid shall be granted only upon concurrence of a majority of the full Board of Trustees.

In all cases, the Declaration of Trust and applicable Bylaws thereof shall be followed and complied with in full.

Amounts of financial aid grants generally range from $100.00 to $1,000.00.

Information on obtaining grants can be obtained presently by mail: 2041 Exchange Drive, St. Charles, Mo 63303, via phone at 1-877-872-2638 (Toll Free) or online at www.tpahq.org/tpa-hearing-trust.

The number of grants and the amount of such grants is determined based on available funds as determined by the Board of Trustees. Recipients who obtain a grant will be required to complete and provide the Acknowledgment Form with applicable supporting documentation.

No relatives of members of the Trust's Board of Trustees are eligible to receive grants. Members or relatives of members of the Travelers Protective Association of America are eligible.

All applicants must include verification of total household income, as explained in the application.

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- Full name of Applicant: _____
  Last First Middle
- Residence Address: _____
  Street City State Zip
- Birth Date _____ Sex: ( ) Male ( ) Female
- Phone Number: _____ U.S. Citizen: ( ) Yes ( ) No
- Email Address: _____

If Applicant is a Minor:

Name of Parent or Guardian: _____
Last First Middle

Address: _____
Street City State Zip

Relationship to Applicant (Natural Parent, Court Appointed Guardian, etc.) _____

- Occupation of Applicant (or Parent, if minor): _____
  - Name of Employer: _____
- Medical Insurance Provider: _____
  Name of Company Type of Coverage

_____
Name of Company Type of Coverage

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- Annual income** of Applicant: _____
- Total annual income** of Household: _____

***ALL household income is to be considered. Please provide the most recent year-end tax filing (1040 form) for members of the household and Social Security statements, if applicable. W2's and paystubs will not be accepted as proof of income.*

- Is the Applicant related or in any way affiliated with a member of the Trust's Board of Trustees, an officer, or a substantial contributor? If so, explain: _____

_____

Please list all household members:

Name	Relationship	Age
Name	Relationship	Age
Name	Relationship	Age
Name	Relationship	Age

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- Have you applied for this grant in the past? ( ) Yes ( ) No
  - If yes, were you approved for the grant? ( ) Yes ( ) No
  - If you were approved, list the amount awarded and the intended use for the previous grant(s):

Year	Amount	Previous Use
Year	Amount	Previous Use
Year	Amount	Previous Use
Year	Amount	Previous Use

  - If you were denied for a previous grant, please explain why: _____

_____

_____

- Describe hearing deficiency in detail: _____

_____

- Onset date of deficiency: _____
- Prior medical treatment (list names/address or doctors): _____

_____

_____

- Intended Use for Grant/Anticipated Costs (be specific): _____

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The Hearing Trust provides grants for persons who experience deafness or hearing loss. Grants may be used for mechanical devices, medical or specialized treatment, or specialized education, as well as speech classes, note-takers, interpreters, and so forth. The specific need or needs must be directly related to hearing loss. In this case, the key phrase is specialized education. If an individual is requesting a grant for tuition assistance, then it must be for schools with specialized programs for students with varying degrees of hearing loss. A grant cannot be used toward tuition, prior to knowing the school that the applicant will be attending.

If Applicant is using grant towards tuition, please fill out this box:

School Applicant is attending: _____

Address: _____
Street City State Zip

Approximate tuition cost annually: _____

Financial Assistance from other sources: _____

_____

- Remarks: _____

_____

All questions are required to be answered for consideration of a grant. Missing information will delay processing of the application. I have provided the information requested, to the best of my knowledge.

I agree that no later than ninety (90) days after a grant is made, I will complete an Acknowledgement Form demonstrating the uses to which such grant was put. I understand that the failure to timely return such Acknowledgement Form may subject me to sanctions, including return of all grant funds received and/or loss of eligibility for future grants from The TPA Hearing Trust.

_____ _____

Date Signature of Applicant (or Guardian if minor)

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FULL RELEASE

In consideration of the furtherance of the purposes, objectives, and work of the TPA Hearing Trust, I hereby grant permission to the TPA Hearing Trust, 2041 Exchange Drive, St. Charles, Missouri 63303-5987, its Trustees and employees, to take photographs and/or videos of the Applicant, and to use photographs and/or videos provided by the Applicant or Guardian. I hereby authorize the exhibition, reproducing, publishing, televising and use of these photographs and/or videos for educational information and advertising purposes, including, but not by way of limitation, publication in the Travelers Magazine and use of said Applicant's name. I grant The TPA Hearing Trust the right to exhibit, assign and transfer in whole or in part, said photographs and/or videos.

I hereby relinquish all right, title and/or interest that I/We may have to such videos, finished pictures, negatives, productions and copies of the original prints and negatives, and further grant unto The TPA Hearing Trust the right to exhibit, assign and transfer in whole or in part, said videos, negatives, original prints, and copies, or facsimiles thereof.

( ) Yes, I consent **Please include Photograph of Applicant ONLY

( ) No, I do not consent

Printed Name of Applicant

Signature of Applicant (or Guardian, if minor) Date

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MEDICAL AUTHORIZATION

I hereby request and authorize you to furnish The TPA Hearing Trust, or its representative, any and all information you may have concerning **the undersigned recipient** with respect to any hearing defect, illness or injury, medical history, consultation, prescription or treatment, including copies of all hospital or medical records and/or imaging records. A copy of this Medical Authorization shall be considered as effective and valid as the original.

Printed Name of Applicant

Signature of Applicant (or Guardian, if minor) Date

MEDICAL CERTIFICATION

(to be completed and signed by medical office)

- Name of Patient: _____
- Diagnosis of hearing defect: _____
  - Degree of loss: _____ Right Db: _____ Left Db: _____
- Date of diagnosis: _____
- Medical recommendation for future treatment: _____
- Estimated cost of recommended treatment and/or equipment: _____
- Prognosis for cure or improvement with treatment: _____
- To the best of your knowledge, is patient able to supply costs of recommended treatment? _____
- If medical treatment and/or mechanical or electronic aids will not benefit patient, is specialized education or training recommended? _____

Signature and Title of Physician, Audiologist, or Other Licensed Provider Date

Contact Phone Number Office Address