beginnings
EMPOWERING PARENTS OF CHILDREN WHO ARE DEAF OR HARD OF HEARING THROUGH EDUCATION AND SUPPORT
guidance for your child's journey™

Welcome to the Grants to Parents Application process. Our hope is to provide hearing and communication related expenses to those families of children who are deaf and hard of hearing and are permanently residing in the state of North Carolina. Our goal is to provide support to many families as we possibly can so please review the application process carefully. Should you have any questions, please do not hesitate to contact us at raleigh@ncbegin.org or at 1.800.541.4327. Thank you for contacting BEGINNINGS for assistance.

BEGINNINGS for Parents of Children Who are Deaf or Hard of Hearing, Inc. is a non-profit organization serving families since 1987. BEGINNINGS was established to provide emotional support and access to information as a central resource for families with deaf or hard of hearing children, from birth to 22.

This grant funds families to **assist** with hearing and communication related expenses only. Examples of hearing related expenses (but not limited to):

- Hearing aid fitting and/or repairs (not to purchase hearing aids)
- Ear molds
- FM systems and accessories
- Insurance deductible and co-pays (there is a maximum of $500 per request)
- Hearing aid batteries and supplies
- Transportation to hearing related appointments
- Classes for communication modalities

CRITERIA:

- Family must have been referred to and served by BEGINNINGS
- Child with hearing loss must be under the age of 22
- Family must currently reside in North Carolina
- Parents/guardians should be able to clearly outline their need for financial assistance and plans of usage of grant funds.
- Parents may re-apply every twelve months; there is a limit of 3 awards per family.

APPLICATION MUST ALSO INCLUDE:

- A current audiogram must be attached to the application (12 months from the application date)
- Photo of child
- Recommendation (using the attached form) from a professional who has worked with your child. For example: a therapeutic, educational or hearing health professional such as a speech-language pathologist, early interventionist, early childhood special educator, teacher of the deaf/hard of hearing or audiologist.
- Privacy Release Form

APPLICATION DEADLINE:
Applications will be accepted on a rolling basis and will be reviewed quarterly.

Dates for accepting application:
- July 31
- October 31
- January 31
- April 30

AWARD PROCESS:
After all applications are screened, eligible applications will be reviewed by the award selection committee. Once the review process is completed, you will be notified via email of award decisions. Letters of notification will also be mailed to all applicants.

Awards will be mailed no later than:
- August 31
- November 30
- February 28
- May 31

beginnings
EMPOWERING PARENTS OF CHILDREN WHO ARE DEAF OR HARD OF HEARING THROUGH EDUCATION AND SUPPORT
guidance for your child's journey™

Grants to Parents Application

Applicant (child) Name: First, MI, Last _____

DOB _____ **Gender**_____

Parent/Guardian name _____

Occupation _____

Relationship to child _____

Mailing and street addresses _____

City/State _____ **Zip code** _____

Home phone number _____ **Mobile number**_____

Email address _____

Preferred method of contact _____

BEGINNINGS Parent Educator _____

Total Amount requested _____

Services child is receiving or will receive in the coming year and total amount paid by family for each:

- Transportation costs $_____
- Overnight stays $_____
- Preschool program $_____
- Audiological Appointments $_____
- Hearing aid purchase $_____
- Hearing aid maintenance (e.g., ear molds, batteries) $_____
- Hearing aid fittings $_____
- Cochlear implant appointments $_____
- Parent/Family Training $_____
- Devices (e.g., FM systems, Assistive Listening Devices for children under age of 5) $_____
- Other _____

Total number of dependents in household, including applicant _____

Total annual gross household income

- $20,000 or less
- $20,001 - $35,000
- $35,001 - $45,000
- $45,001 - $60,000
- $60,001 - $$80,000
- $80,001-$100,000
- $100,000+

What specific hearing-related services/activities are you requesting assistance with? Please consult with your Parent Educator and have them assist you with this part of the application. Be specific about your request. Appointment type and mileage needs to be included with transportation costs. Please check all that pertain to your request and write in any explanation below:

- Transportation $_____ Mileage _____
- Overnight stays $_____
- Audiological appointments $_____
- Hearing aid maintenance $_____
- Hearing aid fittings $_____
- Cochlear implant appointments $_____
- Parent/Family Training $_____
- Devices $_____
- Other Hearing related service $_____

_____
_____
_____
_____

Questions (Please provide responses to the following questions)

- *Describe funding sources you have pursued but are not eligible for and why.*
- *Tell us about your family including any information about children other than the applicant and any difficulties that they might have, as well as any special circumstances.*
- *Describe one of your child's achievements.*
- *If you receive the grant, how will you use it?*

I certify that my responses are accurate and true to the best of my knowledge. I understand that fraudulent or misleading information will make me ineligible for any financial assistance. I understand that if we are selected to receive a grant, BEGINNINGS may release general information regarding the award and I give BEGINNINGS permission to publish, without charge, photographs and narratives.

Print Name _____

Signature_____

Date_____

beginnings
EMPOWERING PARENTS OF CHILDREN WHO ARE DEAF OR HARD OF HEARING THROUGH EDUCATION AND SUPPORT
guidance for your child's journey™

PHOTO RELEASE FORM

I/We, _____ parent/guardian(s) of _____

_____

hereby give BEGINNINGS For Parents of Children Who Are Deaf or Hard of Hearing the right and permission to publish, without charge, photographs and narratives.

These photographs and or narratives may be used in publications, including electronic publications, or in audiovisual presentations, promotional literature, advertising, or in other similar ways.

I/We have read and understand the above.

Signature(s): _____

_____

Names of Above (please print):_____

_____

Month/Date/Year:_____

Address: _____

City: _____ State/Zip Code:_____

Primary contact can be contacted at (circle one): work home cell

Telephone: _____

(optional) E-mail:_____

Disclaimer: Above information is held in confidence and is never released or sold.

beginnings
EMPOWERING PARENTS OF CHILDREN WHO ARE DEAF OR HARD OF HEARING THROUGH EDUCATION AND SUPPORT
guidance for your child's journey™

Professional Recommendation

_____ _____
Name Title/organization

_____ _____
Address Phone number

_____ _____
Relationship to family How long have you known the family?

_____ _____
Name of child Name of parent/guardian

Please rate the following statements:

The family has demonstrated commitment to their chosen communication mode or language for their child:
Strongly agree Somewhat agree Somewhat disagree Strongly disagree Not applicable

The family has demonstrated commitment to the use of appropriate amplification:
Strongly agree Somewhat agree Somewhat disagree Strongly disagree Not applicable

The family has consistently attended appointments/therapies:
Strongly agree Somewhat agree Somewhat disagree Strongly disagree Not applicable

The family has demonstrated an understanding of the importance of consistent follow-through of recommendations outside of therapy settings:
Strongly agree Somewhat agree Somewhat disagree Strongly disagree Not applicable

Optional additional comments:

_____

_____

_____

_____ _____
Signature Date

Please return via email, fax or mail to raleigh@ncbegin.org, (919) 715-4093 or 156 Wind Chime Court, Suite A, Raleigh, NC 27615