



MONTEREY COUNTY OFFICE OF EDUCATION REQUEST FOR HEARING AID REIMBURSEMENT

Employee Name _____ SSN _____ - _____ - _____

Mailing Address _____

Phone Number (_____) _____ - _____ Department _____

The following documents must be attached to request form:

- _____ Medical prescription
- _____ Proof of payment

Amount requested for reimbursement: (Maximum allowed is \$1,500 per ear)

Left ear \$ _____

Right ear \$ _____

Total \$ _____

I declare that the hearing aid that I'm requesting reimbursement for has been medically prescribed, by a qualified doctor, for my own use. I understand that the Internal Revenue Service considers the reimbursement a taxable fringe benefit; therefore it will be paid through payroll and subject to taxation. I further understand that I'm not eligible to request another reimbursement for four (4) years.

Employee Signature _____ Date _____

Business Office Approval _____ Date _____

Submit form to: MCOE Business Office, Attn: Payroll Services Supervisor