



# The Hearing Foundation

(Ear of the Lion Foundation, Inc.)  
850 San Jose Ave., Suite 115 – Clovis, CA 93612  
(800) 327-8077 – (559) 322-5466 Fax: (559) 322-5468 – hearfoundation@aol.com



(05/01/2010)

Dear Applicant,

All applications must have the following information attached.

1. A copy of a HEARING TEST taken within the past 6 months.
2. A MEDICAL CLEARANCE FROM A MEDICAL DOCTOR. The clearance must state hearing aids are recommended. The clearance must be dated within the past 6 months and signed by a qualified physician and audiologist. **M.D. and Audiologist Signatures are required on page D-3a.**
3. **VERIFICATION OF INCOME** (A copy of latest income tax return or a copy of Statement of Benefits from Social Security or a copy of Bank Statement or any document verifying your annual income).
4. SIGNATURES ON ALL DOCUMENTS. Please read and complete all pages of the application. **Don't forget to sign pages D-2b and D-3b.**

**The application cannot be approved unless all of the above is received.**

PLEASE SEND **COMPLETED APPLICATION** TO THE ADDRESS ABOVE.

Thank you

Sincerely,

/s/ *Terry Brooks*

Terry Brooks  
Director of Membership & Development

D-1a



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## PATIENT APPLICATION

**NAME:** \_\_\_\_\_ Date \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_ Phone # (\_\_\_\_\_) \_\_\_\_\_

\_\_\_ Male \_\_\_ Female Date of Birth \_\_\_\_\_ Social Security # \_\_\_\_\_

How long have you lived at this address? \_\_\_\_\_

If under 5 years list previous address \_\_\_\_\_

Married \_\_\_\_\_ Single \_\_\_\_\_ Divorced \_\_\_\_\_ Widowed \_\_\_\_\_ Seperated \_\_\_\_\_

Dependants living at home \_\_\_\_\_ First name and ages \_\_\_\_\_

Employment Status: Employed \_\_\_\_\_ Retired \_\_\_\_\_ Disabled \_\_\_\_\_ Unemployed \_\_\_\_\_

### **FINANCIAL INFORMATION:**

Total Monthly Income: \_\_\_\_\_ Total Monthly Liabilities: \_\_\_\_\_

Home: \_\_\_\_\_ Own \_\_\_\_\_ Rent \_\_\_\_\_

***PLEASE BE SURE TO INCLUDE DOCUMENTATION VERIFYING YOUR ANNUAL INCOME***

**NAME OF RESPONSIBLE ADULT:** (Parent, guardian, etc if applicable)

**NAME:** \_\_\_\_\_ **RELATIONSHIP TO APPLICANT:** \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_ Phone # (\_\_\_\_\_) \_\_\_\_\_

D-2a

**MEDICAL BENEFITS:**

Do you have any medical benefits under any government agency or insurance plan?

Yes \_\_\_\_\_ No \_\_\_\_\_ If yes please indicate:

Medicare \_\_\_\_\_ Media/Cal \_\_\_\_\_ Group \_\_\_\_\_ Private \_\_\_\_\_ CCS \_\_\_\_\_ Other \_\_\_\_\_

If other please Specify \_\_\_\_\_

\_\_\_\_\_ Expiration Date \_\_\_\_\_

**CITIZENSHIP REQUIREMENT:**

Citizenship of Patient \_\_\_\_\_

1. If not a U. S. citizen are you a legal resident? Yes \_\_\_\_\_ No \_\_\_\_\_  
How long? Years \_\_\_\_\_ Months \_\_\_\_\_

2. **Please send copy of your Green card or Immigration Visa Card, if not a citizen of the United States.**

**AUTHORIZATION:**

I hereby authorize The Hearing Foundation to make any investigation concerning me which is necessary to establish eligibility for assistance. This authorization constitutes a full and complete release from any liability resulting from disclosure of the required information. I declare under penalty of perjury under the laws of the United States that the foregoing statement of facts provided by me is true and correct to the best of my knowledge and belief.

**SIGNATURE OF PATIENT**

**OR RESPONSIBLE PARTY: \_\_\_\_\_ DATE \_\_\_\_\_**



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## PATIENT MEDICAL FORM

**PATIENT** \_\_\_\_\_ **Date** \_\_\_\_\_  
 Number & Street \_\_\_\_\_  
 City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

**PHYSICIAN** \_\_\_\_\_ **Date** \_\_\_\_\_

Number & Street \_\_\_\_\_  
 City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
 Phone # (\_\_\_\_\_) \_\_\_\_\_.

Diagnosis (Is ear passage clear of any obstructions) \_\_\_\_\_

***The above patient has been medically evaluated and may be considered a candidate for hearing aids.***

**Required Signature** \_\_\_\_\_ **M.D.**

**AUDIOLOGIST or DISPENSER** \_\_\_\_\_ **Date** \_\_\_\_\_

Number & Street \_\_\_\_\_  
 City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
 Phone # (\_\_\_\_\_) \_\_\_\_\_.

Diagnosis (Please attach audiogram and other relevant exhibits) \_\_\_\_\_

Recommendations \_\_\_\_\_

***Would you be able to take the impressions and do the fitting for this client?***    **YES**            **NO**

**Required Signature** \_\_\_\_\_ **Audiologist or Dispenser**

### STATEMENT OF SPONSORING LIONS CLUB

Name of Sponsoring Club \_\_\_\_\_ District \_\_\_\_\_

Our Club believes that this patient qualifies for assistance from The Hearing Foundation, and we wish to be this patient's sponsoring Club. We will assist the patient in keeping any appointments that the foundation might make for the patient.

Authorized by \_\_\_\_\_ Title \_\_\_\_\_ Phone # (\_\_\_\_\_) \_\_\_\_\_

Number & Street \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Signature \_\_\_\_\_

## AGREEMENT FOR SERVICES

The undersigned Patient (if Patient is a child or under a guardianship arrangement, then parent or guardian shall sign this Agreement) wishes to be referred by the The Hearing Foundation to a health care professional who will assist me in solving my hearing problem. I understand that any health care professional to whom I may be referred is an independent business person separate from the Foundation.

1. My annual **HOUSEHOLD** income is: Family of 2, \$24,000; Family of 3, \$30,000; Family of 4, \$36,000; Family of 5, \$42,000, etc. or less and I understand the Foundation will exhaust all alternative funding before providing assistance. **If my annual household income is more than the amount previously listed, the Foundation may provide assistance depending upon circumstances. Please provide us with a hardship letter explaining your circumstances and submit along with your application.**

2. Our hearing aids are used. They have been cleaned and reconditioned to meet the manufacturer's specifications. All hearing aids are warranted by the Foundation for 6 months after date of issue. If a hearing aid does not meet my needs, the Foundation will make a reasonable effort to provide an aid that will suit my needs.

3. **I will pay a non-refundable fee of \$150.00 for each hearing aid I receive on "Lifetime Loan" from the Foundation.** The Loan Fee is not a purchase, The Hearing Foundation (Ear of the Lion) does not sell hearing aids. I will pay the fee after I have been advised that I am qualified to be loaned a hearing aid from the Foundation and prior to my first appointment with a hearing aid dispenser assigned by the Foundation to prepare my ear molds. **The loan fee is non-refundable and will not be returned under any circumstances.**

4. I am responsible for the care and maintenance of the aid(s), including batteries, for as long as this Agreement remains in force. If I do not maintain the aid(s) properly, the Foundation reserves the right to terminate this Agreement and require that I return the aid(s) to the Foundation. I agree to return the hearing aid(s) to the Foundation when I no longer have a need for them.

5. I am responsible for providing a completed Application, a complete copy of my most recent Federal tax return or equivalent, Patient Referral Form, and an audiogram (hearing test) that is no more than six (6) months old. A physician's referral is required in all cases.

6. I authorize the Foundation and any sponsoring Lions Club to investigate my application to whatever extent it feels is necessary. I agree to provide any information requested by the Foundation and to cooperate in any way I can. I further authorize the Foundation to disclose to any person or entity it feels appropriate any information in my application and any information it develops as a result of its investigations. I certify that all of the information I have provided is true and complete to the best of my knowledge.

7. In consideration of the services that will be provided to me, I hereby release and discharge the Foundation and its Officers and Directors from any and all claims, either known or unknown, arising from any services rendered by the Foundation or by any other persons or entities referred by the Foundation.

**Date** \_\_\_\_\_ **Signature** \_\_\_\_\_

**Patient (or Parent or Guardian, as Appropriate)**

D-3b