# The Hearing Foundation

(Ear of the Lion Foundation, Inc.)
1030 Gettysburg Ave., Suite 100-D – Clovis, CA 93612
(800) 327-8077 –Fax: (559) 291-4666 – hearfoundation@aol.com

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,

Terry Brooks

Terry Brooks
Director of Membership & Development

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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 Annual 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 # (_____)_____

**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 resident 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 _____

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

**Required Signature** _____ **Audiologist**

**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 _____

D-3a

# 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)**