Georgia Lions
Lighthouse Foundation

Better Vision. Better Hearing. ***Better Georgia.***

HEARING SERVICES APPLICATION

5582 Peachtree Road | Atlanta, GA 30341 | Phone: 404.325.3630 | Fax: 770.406.6558

Application Checklist

Please print clearly. Keep a copy of this application.

The following MUST be submitted for this application to be considered: Failure to include these documents will delay your application and increase the time it takes to get your hearing aids. Patients are individually responsible for providing the required documents listed below.

1. **Current hearing test** (less than 6 months old). Must be done or approved by a Lighthouse-Foundation approved provider (page 5).
2. **Lighthouse-approved Hearing Provider Recommendations** (page 4).
3. **Medical Clearance or Medical Waiver** (page 4)
4. **Fully completed application with attached documentation** (see below)

Documentation:

- GA driver license **OR** GA birth certificate **OR** GA identification card **OR** GA voter's registration card **OR** GA Medicaid/Medicare card **OR** Permanent Resident Card (**Please note you will need to send additional documentation to show that you have been a GA resident for at least one year**)

- Copy of first page of rental agreement **OR** mortgage statement **OR** letter from home, shelter, or transitional home stating that you live at that location (on letterhead and signed by home/shelter employee) **OR** notarized letter if living with family or friend **OR** copy of a current utility bill (gas, water, electric)

- **Any of the following items that apply to you and your household:**
  - Last year's tax return
  - Last 3 months of bank statements
  - 3 most current paycheck stubs
  - Most current Social Security Award letter
  - Most current Food Stamp award letter from DFACS
  - Letter from nursing home
  - Unemployment Claim/Wage Inquiry from Dept of Labor
  - Information and documentation of other forms of income: TANF, pension, retirement, child support, etc

THE HEARING AID PACKAGE IS **NOT FREE.** YOU WILL HAVE A **COPAYMENT.**

Please note that due to limited funding and a high demand for hearing services, patients will be placed on a waiting list.

Individuals may apply once every five years for service depending on program funding.

Patient Information

Please answer ALL questions. Print clearly in CAPITAL LETTERS with a dark pen.

If you have any of the below, it is recommended that you consult a medical doctor first. If you do not want a medical examination, Federal Law allows a fully-informed adult to sign a waiver statement declining the medical evaluation (Page 4).

1. **Congenital/traumatic deformity of the ear**
2. **Active ear drainage within the last 90 days**
3. **History of sudden or rapidly progressive hearing loss within the last 90 days**
4. **Acute or chronic dizziness**
5. **Unilateral hearing loss of sudden or recent onset within the previous 90 days**
6. **Audiometric air-bone gap equal to or greater than 15 decibels at 500, 1000, and 2000 HZ**
7. **Visible evidence of earwax (cerumen) or any foreign body in the ear canal**
8. **Pain or discomfort in the ear**

1. Applicant Name:

_____

Title First Middle Last Suffix

2. Name of Parent or Guardian (if applicant is a minor):

_____

Title First Middle Last Suffix

3. Address: _____

4. City: _____, Georgia

5. Zip Code: _____ 6. County _____ 7. Sex: **M** **F**

8. Social Security Number: XXX - XX- _____ 9. Date of Birth _____/ _____/_____

10. Home Phone: (____) _____- _____ 11. Cell Phone: (____) ____- _____ 12. Work Phone: (____) ____- _____

13. Email Address : _____ 14. How long have you been a GA resident? _____

15. Are you employed? **Y** **N** 16. If no, are you actively seeking employment? **Y** **N**

17. If you are unemployed, circle all that apply: **Disabled/Receive SSDI** **Unable** **Retired** **Lost Job** **Other**

18. Race: **White** **African American** **Other** **Hispanic** **Asian**

19. Insurance: Please circle every type of insurance you have. Please be aware that we do no t accept WellCare as payment.

Medicare **Medicaid** **VA** **PeachCare** **Grady Card** **Other** **Kaiser** **None**

20. State the reason(s) why you cannot afford to purchase hearing aids: _____

21. Marital Status: **Married** **Single** **Divorced** **Separated** **Widowed**

22. How did you hear about the Lighthouse Foundation Hearing Program? _____

Financial Information

In the chart below, list everyone - including yourself - living at your address. Include all sources of income for all members of the household. Attach additional household members on separate sheet or list on the back of this page.

Name	Age	Relationship	Dependent (Yes or No)	Source(s) of Income	Amount of Income
		Self	No		$
					$
					$
					$
					$
Total # of People in Household		**Total # of Dependents in Household**		**Total Monthly Income** (Combined income for all members of household)	$

Monthly Expenses

Rent or Mortgage	$
Utilities	$
Food	$
Phone/Cable	$
Credit Cards	$
Insurance (include documentation)	$
Water/Sewage	$
Car Payment	$
Medicine	$
Medical Debt	$

Assets

Savings/Checking Accounts	$
Stocks & Bonds (Market Value)	$
Face Value of C.D.s	$
Value of Home/Land/Property	$
Cars/Trucks	$
Other	$

Additional Expenses	Additional Assets

Provider Recommendation

This section must be completed by the hearing professional who performed the hearing test.
You must include a copy of that current hearing test (audiogram).

The Lighthouse Foundation does not pay for hearing tests.

Business Name: _____

Name and Title of Hearing Professional: _____

Phone Number: _____ Fax Number: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Please specify degree of hearing loss:

Mild Moderate Moderately Severe Severe Profound

Circle the type of hearing aids recommended:

Right Ear: None RIC/BTE ITE BICROS

Left Ear: None RIC/BTE ITE BICROS

Do you require Medical Clearance for this patient? **Yes** **No**

Is this facility a Lighthouse Provider? **Yes** **No**

If no, are you interested in becoming a Lighthouse Provider? **Yes** **No**

Contact us at 404.325.3630 x313 or visit www.lionslighthouse.org for more information.

Medical Waiver

I have been advised by _____(audiologist/hearing aid dispenser) that the Food and Drug Administration has determined that my best health interest would be served if I had a medical evaluation by a licensed physician (preferably a physician who specializes in disease of the ear) before obtaining a hearing aid. **I choose not to have a medical evaluation before obtaining a hearing aid.**

_____ ____/____/____

Signature of Applicant Date

_____ ____/____/____

Witness (if applicant signs with an "X") Date

Medical Clearance

I certify that _____(applicant name) was medically examined on ____/____/___ and may be considered a candidate for hearing aid use. **Must be signed and dated by a licensed physician (M.D.).*

_____ ____/____/____

Signature of M.D. Date

_____

Name of M.D. (Please Print)

Lighthouse Statement

Please Read and Sign This Statement. This MUST be signed by all patients.

"I fully understand Lighthouse services are limited to legal GA residents unable to pay for, or receive from other sources, this assistance. In consideration of these services, I release and discharge all persons rendering such services from any claims I may have arising from services rendered. I am aware that the Lighthouse will not pay for any hearing aids billed to me prior to approval of this application. I also understand my application may be reviewed by a Lions Club, Lighthouse Providers, and/or the Lighthouse staff.

All Information on and attached to this application is true and correct to the best of my knowledge. I also understand that the Lighthouse Foundation has the right to refuse service to any applicant."

_____ _____

Signature of Applicant (or parent if applicant is a child) Date

_____ _____

Witness (if applicant signs with an "X") Date

Authorization of Information/HIPAA

EVERYONE MUST SIGN AND DATE THE BOTTOM OF THIS PAGE.

Please list an emergency contact. If you want us to be able to speak with this person about your services, please check the box on the right. If you want us to speak only with you, do not check the box to the right.

Emergency Contact

1. Name _____
2. Relationship to Applicant: _____
3. Phone: _____
4. Address: _____
5. City _____ 6. State _____ 7. Zip Code _____

☐ Permission to speak with listed contact about your hearing aids?

I understand that the Federal Privacy Rule **(HIPPA)** does not protect the privacy of information if re-disclosed, and therefore request that all information obtained by this person or agency be held strictly confidential and not be further released by the recipient. I further understand that my eligibility for Lighthouse services is not conditioned upon my provision of this authorization. I intend for this document to be a valid authorization conforming to all requirements of the Privacy Rule and understand that my authorization will remain in effect for:

Please check how long you give us permission to speak with the above-listed individual:

◊ Ninety (90) days

◊ One (1) year

◊ Until this specified expiration date: _____/_____/_____

◊ The period necessary to complete all transactions on matters related to services provided to me. I understand that unless otherwise limited by state or federal regulation, and except to the extent that action has been taken based upon it, I may withdraw this authorization at any time.

_____ _____

Signature of Applicant (person applying for hearing services) **Date**

_____ _____

Signature of Authorized Representative **Signature of Witness (if patient signs with an X)**

(Person chosen by the applicant to speak with the Lighthouse)

Lighthouse Foundation Approved Hearing Providers

There are certain hearing providers who work with the Lighthouse Foundation hearing program. This means they accept payment from the Lighthouse Foundation on your behalf. It also means they abide by the guidelines of the Lighthouse Foundation program and agree to provide the services included in your hearing aid package.

For this reason, you **MUST** be a patient of a Lighthouse Foundation-approved hearing provider. A list can be found on our website, www.lionslighthouse.org or by calling 404-325-3630.

What does this mean if you already have a hearing test? Can you use it?

Maybe. All hearing tests must be current. According to Georgia law, that means it must be 6 months old or less. Furthermore, if your hearing test does not come from a Lighthouse-approved provider, our Lighthouse providers *may* require you to get a new test from them before you can proceed to be their patient. If you have a current test you wish to use, you will need to ask your new Lighthouse provider if he/she will accept it.

How do you find a Lighthouse Foundation-approved hearing provider?

You can find a current list of providers at www.lionslighthouse.org, or you can call the Lighthouse Foundation at 404-325-3630 to request a list.

Once you have the list of providers, please follow these three steps:

1. Choose a Lighthouse Provider from the provided list.

2. Call the Provider you have chosen. Tell them that you are applying to the Georgia Lions Lighthouse Foundation for hearing aid assistance and you need a Lighthouse Foundation-approved provider.

    * If you **have** a hearing test that is less than 6 months old, ask them if they will accept it.
    * If you **do not have** a hearing test, tell them you need one.

3. Ask the Provider if they are willing to accept you as a new patient. If the provider agrees to accept you as a patient, you will see this provider for your Lighthouse Foundation-approved hearing appointments.

    * If the provider is not willing to accept you as a new patient, choose another provider from the list who is in your area and repeat the steps above.

Write the name of your Lighthouse Foundation-approved hearing provider here:

_____

Hearing Program Survey: Please circle or place a check mark by your choice. This is MANDATORY for you to be considered for services.

DATE: _____

1. What is your age? a.0-21 b. 22-34 c. 35-50 d. 51-64 e. 65 & up

2. Are you a first time hearing aid user? Yes No

3. Have you received hearing aid(s) from the Lighthouse Foundation before? Yes No

4. How long have you experienced hearing loss?
   a. less than 5 years
   b. 5 to 10 year
   c. 10 to 15 years
   d. more than 15 years

5. How often do you experience the following symptoms? For each choose ONLY ONE of the options:

	Very Frequently	Frequently	Occasionally	Rarely	Never
Tinnitus (Ringing or roaring in the ears)					
Balance Issues					
Vertigo (dizziness)					

6. At the present time, would you say your overall hearing is excellent, good, fair, poor, or very poor. You may also describe your overall hearing in the comment section.
   a. Excellent
   b. Good
   c. Fair
   d. Poor
   e. Very Poor
   f. Comment:_____

7. Please circle **Yes, No, Sometimes, or N/A** for each statement below.

	Yes	No	Sometimes	N/A
Does a hearing problem cause you to feel frustrated when talking to others?				
Do you have difficulty hearing when someone speaks in a whisper?				
Do you feel handicapped by a hearing problem?				
Does a hearing problem cause you difficulty when visiting friends, relatives, or neighbors?				
Do you feel that any difficulty with your hearing limits or hampers your personal or social life?				
Does a hearing problem cause you difficulty when in a restaurant with relatives of friends?				

8. How well are you able to do the following activities? For each activity choose ONLY ONE of the following options: With a lot of difficulty, With some difficulty, Not sure, With some ease, With great ease, or N/A.

	With a lot of difficulty	With some difficulty	N/A	With some ease	With great ease
Be independent					
Communicate with physician at medical appointments					
Communicate at employment interviews					
Take care of others (children, spouse, elderly)					
Engage in group discussions or activities with friends and family					
Hear the doorbell or telephone the first time it rings					
Hear the smoke alarm					
Drive a car					
Participate in hobbies and social activities					
Other (please list the name of the activity: _____)					

9. Are you a student? Yes No

If you answered yes, with your current hearing, how well are you able to do the following activities? For each activity choose ONLY ONE of the following options: Very well, Well, Difficult, Very Difficult, or N/A

	Very Well	Well	Difficult	Very Difficult	N/A
Communicate with teacher and classmates					
Listen to audio presentations in the classroom/lecture hall					
Communicate with others in the library					
Complete assignments					
Participate in class discussions					

10. How were you referred to the Lighthouse Foundation?

a. Department of Family and Children Services
b. APS Healthcare
c. United Healthcare
d. Medicaid/Medicare Specialist
e. Nursing Home
f. Senior Center
g. Vocational Rehabilitation Services
h. Lions Club
i. Audiologist/Hearing Aid Dispenser
j. Website
k. Newspaper Article
l. Other:_____