# 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

Dear Applicant,

Revised June 2021

Thank you for contacting The Hearing Foundation, legally referred to as Ear of the Lion Foundation for assistance.

Our program is not for everyone. It is dedicated to assist qualified low-income persons in **California & Nevada** with their hearing problems, who are not eligible for any government-assisted programs, but are diagnosed as needing hearing aids. Annual Household income must be less than the following: Family of 1, $22,540; Family of 2, $30,485; Family of 3, $38,430; Family of 4, $46,375; Family of 5, $54,300, and going up in increments of approximately $8,500 per additional dependent. **If annual income is more than the amount previously listed, the foundation may provide assistance depending on circumstances. Potential clients over the limit are asked to include a hardship letter, which is then reviewed by the Board of Directors.**

Our hearing aids are used. They have been cleaned and reconditioned to meet the manufacturer's specifications. The aids come with a 12 month repair warranty. There is no coverage for Loss & Damage. The aids are recommended by the provider based on what is best for your hearing loss. There is no trial period.

**There is a non-refundable fee of $150.00 for each hearing aid you 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. You will be asked to pay the fee after you have been advised that you are qualified to receive aids from the foundation. Upon receipt you will be assigned to the Audiologist/Hearing Aid Dispenser. **The loan fee is non-refundable and will not be returned under any circumstances.**

**Please submit the following information:**

- Hearing Test taken within the past 6 months.
- Medical Clearance or Medical Waiver must be completed, signed and dated where appropriate, within the past 6 months. ***Please note: If you choose to fill out a Medical Waiver, at the Discretion of the Audiologist/Hearing Aid Dispenser, a Medical Clearance may still be required prior to you being fit with hearing aids.***
- If not a US citizen you must provide proof of legal residency
- Verification of Annual income (SSI, retirement etc.) If you are required to file income taxes please submit a copy of the first two pages of your Federal Tax Return.

Please send completed application to:

The Hearing Foundation (Ear of the Lion)
850 San Jose Ave., STE 115
Clovis, CA 93612

Thank you,

**Terry Brooks,**
**Director of Patient Care, Membership & Development**

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## PATIENT APPLICATION

Date: _____

Applicant's Name: _____

Address: _____ APT # _____

City: _____ State _____ Zip _____ Phone # (_____)_____

Date of Birth: _____ Social Security # _(Last 4)__XXX-XX-_____ ☐ Male ☐ Female

Citizenship of Patient: _____ **If not a US citizen you must provide proof of legal residency**

Marital Status: ☐ Married ☐ Single ☐ Divorced ☐ Widowed ☐ Seperated

Employment Status: ☐ Employed ☐ Retired ☐ Disabled ☐ Unemployed

Employer Name: _____

Number in Household: _____ (Household is defined as all those living together or dependent on each other)

**FINANCIAL INFORMATION**

Total Monthly Income: _____ Total Monthly Liabilities (Bills): _____

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

***You must enclose first two(2) pages of last years Federal Income Tax Return, if you filed. If you did not file, please provide documents showing all Annual income, such as Statement of Benefits from Social Security, retirement payments, W2 etc.***

**NAME OF RESPONSIBLE ADULT:** *(Only complete for applicants under 18 years old, or if you are of legal capacity, such as POA)*

Name: _____ Relationship to Applicant: _____

Address: _____ APT # _____

City: _____ State _____ Zip _____ Phone # (_____)_____

**MEDICAL BENEFITS:**

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

Yes _____ No _____ If yes, please indicate:_____

Please note: If you have Medi-Cal you may qualify for aids through them. Please check with Medi-Cal prior to completeing this application

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## PATIENT MEDICAL FORM

PATIENT _____ Date _____
Number & Street _____
City _____ State _____ Zip _____

*ONE OF THE FOLLOWING MUST BE COMPLETED AND SUBMITTED WITH THE APPLICATION.*
*All applicants under the age of 18 are required to have a Medical Clearance*

**OPTION 1: MEDICAL CLEARANCE FOR HEARING AID USE**

TO BE SIGNED BY THE APPLICANT'S MEDICAL DOCTOR

Date: _____

Applicant's Name (please print): _____

The applicant listed above has been medically examined and may be considered a candidate for hearing aid use.

Physician's Name (please print): _____

Physician's Signature: _____

**If you wish to proceed with a hearing aid without the FDA recommended medical evaluation, you must review and sign the statement below.**

**OPTION 2: STATEMENT OF MEDICAL WAIVER:**

I have been advised by The Hearing Foundation (Ear of the Lion Foundation) that the FDA has determined that my best health interest would be served by having a medical evaluation by a licensed physician (preferably one specializing in diseases of the ear) before acquiring a hearing aid. I certify that I am over 18 years of age and do not wish to have a medical evaluation before acquiring a hearing aid.

I further understand that a copy of this statement will be kept on file by The Hearing Foundation (Ear of the Lion) in accordance with the Food and Drug Administration regulations.

***Please note, at the Discretion of the Audiologist/Hearing Aid Dispenser, a Medical Clearance may still be required prior to you being fit with hearing aids.***

_____ _____ _____
Patient Name Date Signature

**AUDIOLOGIST or DISPENSER _____ Date _____**
Address:_____
City _____ State _____ Zip _____

Phone # (_____) _____.

Recommendations _____
_____

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

**Signature _____Audiologist or Dispenser**

Please note: You are not responsible for finding a sponsoring Lions Club.

**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**

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.

**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.**

**RELEASE OF CLAIMS**

I for myself, my heirs, personal representatives, executors, administrators, or assigns, and on behalf of the patient if the patient is other than myself and I am the responsible party for the patient, waive, release and forever discharge The Hearing Foundation (Legally reffered to as Ear of the Lion Foundation), California and Nevada Lions Clubs, their directors, officers, agents, representatives, successors and all coooperating entities and individuals from all claims, losses, damages which now exist or may hereafter arise in connection with my and/or the patients participation with any services rendered through The Hearing Foundation (Ear of the Lion)

**RELEASE OF INFORMATION**

To the best of my knowledge, I represent the information on this form to be correct. I understand the information I submit to The Hearing Foundation (Ear of the Lion) is subject to verification. I acknowledge and understatnd this release thoroughly and authorize any service provider contracted the by The Hearing Foundation (Ear of the Lion) to release to The Hearing Foundation (Ear of the Lion)any information required.

***The Hearing Foundation (Ear of the Lion) reserves the right to change these terms and conditions at any time without prior notice***

**Date _____ Signature _____**

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