APPLICATION FOR
HEARING AID ASSISTANCE

Name: _____ Age: _____ Marital Status: _____

Address: _____ Birthdate: _____ Sex: _____

City / State / Zip: _____

Phone: _____ E-Mail: _____ Number in Family: _____

Describe Problems: _____

_____

Have you been seen by an Audiologist or Physician? Yes _____ No _____

Who: _____ When: _____

Have you applied to another agency for assistance? Yes _____ Date _____ No _____

Agency Name (if yes): _____

Are you on Medicaid? Yes _____ No _____

List below any income. This includes SSL, Social Security, Disability, Welfare, Retirement Food Stamps, salary as well as any income from your spouse.

Sources of Income	**Amount**
1. _____	$ _____ wk / mo / yr
2. _____	$ _____ wk / mo / yr
3. _____	$ _____ wk / mo / yr
4. _____	$ _____ wk / mo / yr

Do you own _____ or rent _____ your home? Monthly payment: $ _____

Do you own a car _____ or truck _____? Year _____ Model: _____

Other Assets: _____

_____

Applicant: Do Not Write Below This Line

Date mail to applicant: _____ Date returned to State Office: _____ Ck included? _____

Sponsoring Lions Club _____ Date Approved / Denied _____

Club Sec, address phone: _____

_____

District Chairman: _____ Date Approved / Denied _____