# CENTRAL VIRGINIA LIONS HEARING AID BANK

**10286 Staples Mill Road #131 Glen Allen, VA 23060**

**(804) 248-9938 Lionscvhab@gmail.com www.lionshabva.org**

## *APPLICATION FOR ASSISTANCE*

INSTRUCTIONS: **This is a three section form. The first section requests information on the applicant/ verification of need and should be completed by the applicant. The second section determines hearing loss and the gain to be provided by the hearing aid and must be completed and signed by an Audiologist or a Hearing Aid Specialist. Section three must be completed by an ENT or your primary care physician. If you have already had your hearing test, take this form to the provider who performed your test.**

SECTION I: **APPLICANT INFORMATION / VERIFICATION OF NEED FOR ASSISTANCE**

Applicant Name: _____ Birth Date: _____

Address: _____

City: _____ ZIP: _____ Phone: _____

Email: _____ Social Security #: _____

Is Applicant Head of Household? ( ) Yes ( ) No Number of persons in household _____

If not name of Head of Household _____ SS# _____

***Do not leave the following line blank or use zero, consider all forms of income - rent subsidy, SNAP, child support, etc. Failure to show household income will be an automatic rejection of this application.***

Household Annual Gross Income: _____ Source of income: _____

Insurance/Medicare/Medicaid Coverage? ( ) Yes ( ) No Policy or I.D.# _____

Name and Location of Insurance Company _____

What other funding sources have been explored? _____

I, the undersigned, am requesting charitable assistance from the Central Virginia Lions Hearing Aid Bank. I understand that the financial information I provide will be used to determine my eligibility to receive assistance. I understand the the Hearing Aid Bank has the sole discretion in approving or disapproving my application for assistance. If my request is approved, I will accept and comply with the policies, procedures and instructions concerning scheduling and obtaining the services provided. The applicant will be responsible for a co-pay of $50.00 to be paid to the fitting provider at the time of the fitting of the instrument(s). The Hearing Aid Bank will not replace lost or damaged instruments. Consult your provider on insurance coverage.

Signature of Applicant: _____ Date _____

Signature of person filling out this form if not applicant: _____

Print Name: _____ Phone #: _____