



HEARING SERVICES APPLICATION

Please print clearly in capital letters. Use black pen only. Keep a copy of this application.

QUALIFICATIONS

To qualify for Lighthouse hearing services, you must:

- Be a Georgia resident for **at least one year**
- Meet our income requirements
- **Submit ALL REQUIRED DOCUMENTS.** If any of the above documents are not included with your application, we will send a letter asking for it. **This could add months to the time it takes to get your hearing aids.**

APPROVAL PROCESS

- You will receive notice BY MAIL stating whether or not you qualify for our hearing aid package, which includes a digital hearing aid, ear mold, and three appointments with a Lighthouse provider.
- The package cost is determined on a sliding scale based on household monthly income and type of hearing aid needed.
- If you qualify, the letter will include the cost of the hearing aid package.

REQUIRED DOCUMENTS

Make sure all of the following documents are COMPLETED and ENCLOSED before mailing or faxing. Send COPIES, not originals. **If any of these documents are not included, we will send a letter asking for it.**

This could add months to the time it takes to get your appointment.

- Completed Application
- Required documents: ONE form of identification, ONE proof of residency, and ALL available proofs of income.
- Recent hearing test (less than 6 months old) from a Lighthouse provider. Contact the Lighthouse for a list of providers in your area.
- Authorization of Release of Information

| <i>Choose ONE form of ID and ONE proof of residency</i> | | <i>Send ALL documents which apply for you or anyone living at your address</i> |
|--|---|---|
| IDENTIFICATION | PROOF OF RESIDENCY | PROOF OF INCOME |
| <ul style="list-style-type: none"> <input type="checkbox"/> GA Driver's License <input type="checkbox"/> Georgia Identification card <input type="checkbox"/> GA birth certificate <input type="checkbox"/> Voter's Registration card <input type="checkbox"/> GA Medicaid card | <ul style="list-style-type: none"> <input type="checkbox"/> Copy of first page of your lease (rental) agreement <input type="checkbox"/> Mortgage statement <input type="checkbox"/> Letter from home, shelter, or transitional home stating that you live at that location (on letterhead and signed by home/shelter employee). <input type="checkbox"/> Current copy of utility bill (gas, water, electric) | <ul style="list-style-type: none"> <input type="checkbox"/> Last year's tax return <input type="checkbox"/> Last 3 months of bank statements <input type="checkbox"/> 3 current pay check stubs <input type="checkbox"/> Social Security Administration Award Letter. (If you receive direct deposit, circle the item on the bank statement) <input type="checkbox"/> Food Stamp papers from DFACS (award summary) <input type="checkbox"/> Letter from nursing home on amount received for personal expenses <input type="checkbox"/> Unemployment Claim/Wage Inquiry statement <input type="checkbox"/> Information, including monthly amount received, of any other sources of income (ex: TANF, pension, retirement, child support) |

ATTACH ALL REQUIRED DOCUMENTS TO THIS APPLICATION

GENERAL PATIENT INFORMATION

If this is your first time using hearing aids, we suggest that you first get an examination by a medical doctor (preferably an ear specialist) to check for any of the following conditions:

- | | |
|--|---|
| <ol style="list-style-type: none"> 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 | <ol style="list-style-type: none"> 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 |
|--|---|

If you have any of the above, please consult a medical doctor first. If you do not want a medical examination, the Federal Law allows a fully-informed adult to sign a waiver statement declining the medical evaluation.

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

1. Applicant Name:

| | | | | |
|-------|-------|--------|------|--------|
| Title | First | Middle | Last | Suffix |
|-------|-------|--------|------|--------|

2. Name of Parent (if applicant is a child):

| | | | | |
|-------|-------|--------|------|--------|
| Title | First | Middle | Last | Suffix |
|-------|-------|--------|------|--------|

3. Address:

| |
|--|
| |
| |

4. City:

| | |
|--|-----------|
| | 5. State: |
|--|-----------|

6. Zip Code:

| | | |
|--|-----------|---------------------------|
| | 7. County | 8. Sex: M F |
|--|-----------|---------------------------|

9. Social Security Number: ____ - ____ - ____

10. Date of Birth ____ / ____ / ____

11. Home Phone:

| | | | | | | |
|--|--|--|--|--|--|--|
| | | | | | | |
|--|--|--|--|--|--|--|

12. Cell Phone:

| | | | | | | |
|--|--|--|--|--|--|--|
| | | | | | | |
|--|--|--|--|--|--|--|

13. Work Phone:

| | | | | | | |
|--|--|--|--|--|--|--|
| | | | | | | |
|--|--|--|--|--|--|--|

14. Email Address _____

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

17. If you are unemployed, why? Circle all that apply:

Disabled (circle only if you receive SSDI) Not Able Retired Lost Job Other

18. How long have you been a legal Georgia resident? _____ **Years**

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

20. Insurance: Please circle every type of insurance you have.

Medicare Medicaid VA PeachCare Grady Card Other None

21. State reason(s) why you cannot afford to purchase hearing aids:

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

ATTACH ALL REQUIRED DOCUMENTS TO THIS APPLICATION

FINANCES

List everyone, including yourself, living at your address. (Please attach additional household members on separate sheet)

Name: _____ **Dependent?** Y N

Relationship: _____ **Age:** _____

Amount of Monthly Income: _____ **Source of Monthly Income:** _____

Name: _____ **Dependent?** Y N

Relationship: _____ **Age:** _____

Amount of Monthly Income: _____ **Source of Monthly Income:** _____

Name: _____ **Dependent?** Y N

Relationship: _____ **Age:** _____

Amount of Monthly Income: _____ **Source of Monthly Income:** _____

TOTAL NUMBER OF DEPENDENTS: _____

Total Monthly Household Income: \$ _____ **Total Number of People in Household:** _____
 (Combined income of all people living at your address)

MONTHLY EXPENSES:

| | | | |
|------------------|----|--------------|----|
| Rent or Mortgage | \$ | Gas (home) | \$ |
| Power | \$ | Water/Sewage | \$ |
| Food | \$ | Medicine | \$ |
| Phone | \$ | Insurance | \$ |
| Credit Cards | \$ | Medical Debt | \$ |
| Car Payment | \$ | Other | \$ |
| Student Loans | \$ | | |

ASSETS:

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

ATTACH ALL REQUIRED DOCUMENTS TO THIS APPLICATION

LIGHTHOUSE STATEMENT

Please Read and Sign This Statement:

"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

EMERGENCY CONTACT INFORMATION / HIPAA AGREEMENT

If you want us to be able to speak with a friend, family member, caretaker, or social worker, complete all information. If you want us to speak only with you, do not check the box to the right. **EVERYONE MUST SIGN AND DATE THIS PAGE.**

1. Name _____

2. Relationship to Applicant: _____

3. Emergency Phone: _____

4. Address: _____

5. City _____ 6. State _____ 7. Zip Code _____

Permission to speak with him/her 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 your friend or family member.**

ninety (90) days until this specified expiration date: ____/____/____

one (1) year 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 sight services)

Date

Signature of Witness (with title of relationship)

Signature of Authorized Representative
(Person chosen by the applicant to speak with the Lighthouse)

ATTACH ALL REQUIRED DOCUMENTS TO THIS APPLICATION

SURVEY: MUST BE COMPLETED

Thank you for completing this survey. The results from this survey will allow us to assess the services you receive. To fill out survey online (which may speed up the application process), go to <https://www.surveymonkey.com/s/F3QVG3X>.

I have completed this survey online: **Yes** **No**

Name: _____ **Date of Birth:** ____/____/____

For Questions 1-8, please circle Yes or No:

- | | | |
|---|------------|-----------|
| 1. Are you a first time hearing aid user? | Yes | No |
| 2. Do you currently wear hearing aid(s)? | Yes | No |
| 3. If you currently wear hearing aid(s), are they working properly? How long have you worn these hearing aids? <input type="text"/> <input type="text"/> Years | Yes | No |
| 4. Have you ever received hearing aid(s) from Vocational Rehabilitation Services? | Yes | No |
| 5. Have you ever received hearing aid(s) from the Lighthouse Foundation? | Yes | No |
| 6. Are you employed? | Yes | No |
| 7. Are you seeking employment? | Yes | No |
| 8. How long have you experienced hearing loss? <input type="text"/> <input type="text"/> Years | | |

For Question 9 - 10, please circle all that apply:

9. If you currently wear hearing aid(s), what resources did you use to purchase the hearing aid(s)?
- | | | |
|--------------|--|-----------------------|
| Family | Credit Program | Lighthouse Foundation |
| Nursing Home | HMO, Insurance, VA Benefits Foundation | |
| Cash | Charity Organization: _____ | |
10. How were you referred to the Lighthouse Foundation?
- | | | |
|------------------------------|--------------|---------------------------------------|
| Medicare/Medicaid Specialist | Nursing Home | Dept. of Family and Children Services |
| APS Healthcare | Lions Club | Vocational Rehabilitation Services |
| United Healthcare | Website | Audiologist/Hearing Aid Dispenser |
| Newspaper Article | Other | |

For Questions 11 - 20, please circle Yes, No, or Sometimes:

- | | | | |
|---|------------|-----------|------------------|
| 11. Does your hearing problem cause you to feel | Yes | No | Sometimes |
|---|------------|-----------|------------------|

ATTACH ALL REQUIRED DOCUMENTS TO THIS APPLICATION

| | | | |
|---|------------|-----------|------------------|
| embarrassed when you meet new people? | | | |
| 12. Does your hearing problem cause you to feel frustrated when talking to members of your family? | Yes | No | Sometimes |
| 13. Do you have difficulty hearing when someone speaks in a whisper? | Yes | No | Sometimes |
| 14. Do you feel handicapped by a hearing problem? | Yes | No | Sometimes |
| 15. Does your hearing problem cause you difficulty when visiting friends, relatives, or neighbors? | Yes | No | Sometimes |
| 16. Does your hearing problem cause you to attend religious services less often than you would like? | Yes | No | Sometimes |
| 17. Does your hearing problem cause you to have arguments with family members? | Yes | No | Sometimes |
| 18. Does your hearing problem cause you difficulty when listening to TV or radio? | Yes | No | Sometimes |
| 19. Do you feel that any difficulty with your hearing limits or hampers your personal or social life? | Yes | No | Sometimes |
| 20. Does your hearing problem cause you difficulty when in a restaurant with relatives or friends? | Yes | No | Sometimes |

For Questions 21-25, please circle the best answer.

21. The members of my family are annoyed with my loss of hearing.

Strongly disagree Slightly disagree Neither Slightly agree Strongly agree

22. I tend to be negative about life in general because of my hearing loss.

Strongly disagree Slightly disagree Neither Slightly agree Strongly agree

23. Since I have trouble hearing I hesitate to meet new people.

Strongly disagree Slightly disagree Neither Slightly agree Strongly agree

24. I do not enjoy my job as much as I did before I began to lose my hearing.

Strongly disagree Slightly disagree Neither Slightly agree Strongly agree

25. Conversations in a noisy room prevents me from attempting to communicate with others.

Strongly disagree Slightly disagree Neither Slightly agree Strongly agree

ATTACH ALL REQUIRED DOCUMENTS TO THIS APPLICATION