Georgia Lions
Lighthouse Foundation
Better vision. Better hearing. ***Better Georgia.***

Thank you for contacting the Georgia Lions Lighthouse Foundation Hearing Program for hearing aid assistance. The Lighthouse is only an administrative office. We partner with statewide audiologists and hearing aid dispensers in providing our applicants with hearing services.

The Lighthouse offers a hearing aid package, which includes hearing aid, ear mold, and three appointments to the Lighthouse Provider. (Please refer to Brochure for more information) The cost of the hearing aid package is on a sliding scale and is determined by household monthly income and type of aid needed. If applicant meets eligibility requirements, the payment request letter will include the cost of the hearing aid package.

Persons under the age of 21 can obtain hearing aids through GA Medicaid at 1-866-211-0950 or 770-570-3373. Children may also obtain hearing aids through the Children's Miracle Ear Foundation at 1-800-234-5422. If you are not a resident of GA, we suggest you contact Hear Now, the National Hearing Aid Bank at 1-800-648-HEAR for further assistance. If your income is over 200% of the federal poverty guidelines, we suggest you contact AUDIENT at 1-877-283-4368 for further assistance.

Make sure you fill out the application form completely and include the required documents. Forms that are not completed could cause your application to be delayed or denied. Make a copy of the application for yourself and mail the original to the: Georgia Lions Lighthouse Foundation 1775 Clairmont Rd Decatur, GA 30033

1. Identification (Please provide one of the following):

a. GA Driver's License
b. State of GA Identification Card
c. GA birth certificate
d. Voter's Registration Card, **OR**
e. Georgia Medicaid Card

(If you are a Georgia Medicaid Patient, please attach a copy of the Georgia Medicaid Card with your application)

2. Proof of Residency (Please provide one of the following):

a. Lease Contract (if renting)
b. Mortgage Statement if you own your home
c. Referral from shelter or transitional home, **or**
d. Referral from nursing home

3. Proof of Income: Household income must include all persons residing at the applicants address.

Please provide the following information for everyone living at the applicants address:

Last years Tax Return and any of the following that apply

a. Three current pay check stubs
b. Social Security Administration Award Letter
c. Food Stamp Papers from Family & Children Services (award summary notification)
d. Unemployment claim, if unemployed – wage inquiry statement from GA Dept. of Labor
e. Information indicating the applicant is receiving TANF, Social Security Disability, Pension, Retirement, Veterans Administration Benefits, or any other sources of income
f. Last three months of bank statements **and/or**
g. Letter from nursing home stating income benefits

4. Hearing Test must be completed by a Lighthouse Provider. Please contact Lighthouse for a list of Providers in your area. Hearing test cannot be older than 6 months. The Lighthouse does not pay for the hearing test. Medicaid and Medicare may or may not cover an annual hearing exam.

5. Authorization of Release of Information: Complete this form only if you want someone else besides yourself to contact the Lighthouse Foundation on the status of your hearing aid application. An example would be the applicant's spouse or sibling.

APPLICANT GENERAL INFORMATION

1. Applicant's Name: ____
First Middle Last

2. Name of Parent (if applicant is a child): ______________________________
First Middle Last

3. Address: ____

4. City, State, Zip Code: ___________________________________

5. Home Phone Number: _______________ 6. Emergency Phone Number: _______________

7. Date of Birth ____/____/____ 8. Sex (M or F): _____________________

9. Social Security Number: _____-_____-_____ 10. Email Address: ________________________

11. County: ______________________________

12. Race (White, African American, Hispanic, Other): __________________________________

13. Are you employed? (Yes or No) _____ If No, are you seeking employment? (Yes or No) ______

14. If applicant does not work, please circle all that apply:

Disabled Not Able Retired Lost Job Student Other

15. Georgia Medicaid (Yes or No):_________16. Do you receive **SSDI** (Yes or No) __________

17. How long have you been a legal Georgia resident? _________________________________
(Please include proof of identification as instructed on page one)****

18. State reasons you cannot afford to purchase hearing aid(s)?__________________________

____

19. Marital Status: (Married, Single, Divorced, Separated, Widowed) _____________________

20. Names of persons living at the same address as you. ****(Please include proof of income for each person living in your household as instructed on page one)****

Name Age Relationship **Name Age Relationship**

1)____4)____

2)____5)____

3)____6)____

FINANCIAL INFORMATION

21. List monthly income received by you and all persons living at your address. ****(Please include proof of monthly income as instructed on page one)**** If person works list Employer and Monthly Salary. List all Benefits received by each person in the household: Supplemental Security Income (SSI), Social Security Disability (SSDI), Social Security, Food Stamps, Welfare, Veteran's Benefits (VA), Pension, Retirement Benefits, Child Support, or Other Income.

Name	**Source of Monthly Income**	**Amount ($) of Monthly Income**

1) ____

2) ____

3) ____

22. **List monthly expenses:**

a) Rent or Mortgage: $________ b) Gas(home): $_______ c) Power: $_______________

d) Water/Sewage: $__________ e) Food $____________ f) Medicine $_____________

g) Phone: $ ________________ h) Auto Payment $ _____ i) Credit Cards $ __________

j) Insurance (Life, Health, Car):$_________ k) Other expenses:$ ______ l) Medical Debt: $__________

23. How did you find out about the Lighthouse Hearing Aid Program?

Newspaper___ DFCS___ Hearing Provider___ Senior Center___

Lions Club___ Nursing Home___ Internet____ Other_______________________

LIGHTHOUSE STATEMENT

Applicant Must 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 aid billed to me prior to approval of this application. I also understand my application may be reviewed by a Lions Club member, Lighthouse Provider, Public Service Commission, 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 Date

____ ________________________________

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

AUDIOLOGIST/DISPENSER RECOMMENDATION

This section must be completed by the hearing professional.**(Please include copy of hearing test (audiogram) as instructed on page one)**

Business Name: ____

Name and Title of Hearing Professional: ____

Phone Number: ___________________________ Fax Number: __________________

Mailing Address: ____

City, State, Zip Code: ____

Email Address: ____

What contributed to the applicant's hearing loss?

__ Heredity __Work-Related Injury __Aging __Other

Please specify the applicant's degree of hearing loss:

____Mild ____Moderate ____Moderately Severe ____Severe ___Profound

Please indicate the type and number of aid(s) recommended:

Right Ear: ___None ___BTE ___ITE **Left Ear**: ___None ___ BTE ___ ITE

Is this facility a Lighthouse Provider: ______Yes _____No

If No, are you interested in becoming a Lighthouse Provider? _____Yes _____No

Please contact us at 404-325-3630 Ext 305 or visit our website**, www. lionslighthouse.org**, for more information.

MEDICAL 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 specifically check for any of the following conditions:

1. Visible congenital or traumatic deformity of the ear
2. History of active drainage from the ear 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(Hz), 1000 (Hz), and 2000
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.

MEDICAL CLEARANCE FOR HEARING AID USE

Medical Clearance must **only** be signed and dated by a physician

This statement must be completed and signed by a licensed physician (M.D.). Applicants may select to sign the Medical Waiver below.
"I certify that ________________(applicant name) was medically examined on __________(date) and may be considered a candidate for hearing aid use."

___________________________________ ____________________________
Signature of M.D. Date

____
Name of M.D. (Please Print)

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 Applicant Date

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

SURVEY

Thank you for completing this survey. The results from this survey will allow us to assess the services you receive. This survey will take approximately 20 minutes to complete.

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? **Yes** **No**
   How long have you worn these hearing aids? _______Years
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? _________ 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)?

   a. Family b. Charity Organization Name:__________________________ c. Nursing Home

   d. HMO, Insurance, VA Benefits e. Cash f. Credit Program g. Lighthouse Foundation

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 ____________________

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

11. Does your hearing problem cause you to feel embarrassed when you meet new people? **Yes** **No** **Sometimes**

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.

a. Strongly disagree b. Slightly disagree c. Neither d. Slightly agree e. Strongly agree

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

a. Strongly disagree b. Slightly disagree c. Neither d. Slightly agree e. Strongly agree

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

a. Strongly disagree b. Slightly disagree c. Neither d. Slightly agree e. Strongly agree

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

a. Strongly disagree b. Slightly disagree c. Neither d. Slightly agree e. Strongly agree

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

a. Strongly disagree b. Slightly disagree c. Neither d. Slightly agree e. Strongly agree

AUTHORIZATION FOR RELEASE OF INFORMATION

This form should only be completed if the applicant wants someone else to contact the Lighthouse about their hearing aid application.

I hereby request and authorize: ____
(Name of Person that the Applicant wants to Obtain their Private Health Information)

____
Address of above Named Person

____
City, State, Zip Code

to obtain from: **Georgia Lions Lighthouse Foundation**
1775 Clairmont Rd
Decatur, GA 30033

the following types of information from my records (and any specific portion thereof):

____

For the purpose of: ____

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 One)

____ninety (90) days until I specify an earlier expiration date here: ______________________

____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 Hearing Aids) **Date**

____
Signature of Witness (Title of Relationship)

____
Signature of Authorized Representative
(Person that has the right to Applicants Private Health Information)