

LIONS ASSOCIATION for SIGHT and HEARING of Maryland, Inc.

**HEARING AID ASSISTANCE REQUEST**

(Rev. 9/21/2018)

1. Name of Requesting Club: \_\_\_\_\_ Date: \_\_\_\_\_  
Requested by: \_\_\_\_\_ Phone/email: \_\_\_\_\_  
Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_ Zip: \_\_\_\_\_  
➤ **The club contact will receive a copy of the assignment that goes to the individual. Contact party to determine that he/she has made an appointment, will be able to keep it, and has transportation.**
2. Party in need: \_\_\_\_\_ DOB \_\_\_\_\_ Age: \_\_\_\_\_  
Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_ Zip: \_\_\_\_\_  
Phone: \_\_\_\_\_ Employer: \_\_\_\_\_
3. Contact if other than above: \_\_\_\_\_  
Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_ Zip: \_\_\_\_\_  
Phone: \_\_\_\_\_ Relationship: \_\_\_\_\_
4. Need: Complete work up \_\_\_\_\_ Repair of Aid \_\_\_\_\_ Ear Mold Made \_\_\_\_\_  
Other: \_\_\_\_\_
5. Has party been to audiologist? \_\_\_\_\_ Who? \_\_\_\_\_ Date: \_\_\_\_\_  
Description of hearing loss: Single \_\_\_\_\_ Bilateral \_\_\_\_\_ **(Attach copy of audiologist's report)**
6. Amount party/club will pay: \_\_\_\_\_ For one aid \_\_\_\_\_ Two aids \_\_\_\_\_ As needed \_\_\_\_\_
7. Remarks: \_\_\_\_\_

**Applicant Must Read and Sign These Statements:**

- I fully understand these services are limited to individuals unable to pay for or receive hearing aids from other sources of assistance including insurance. In consideration of these services, I release and discharge all persons rendering such services from any claims I may have arising from services so rendered. I am aware that a hearing aid billed to me prior to the approval of this application will not be paid for by this service.
- I understand hearing aids are provided by Lions Clubs International and audiometric and hearing aid services are provided by Towson University Speech, Language, and Hearing Center (TU).
- I also understand my application may be reviewed by Lions organizations and hearing care professionals directly involved in providing this service. These forms will be kept on file by these Lions organizations and hearing care professionals. These documents will be kept confidential and not shared with third parties unless provided for under law.
- Payment for all audiology testing is the responsibility of the applicant. If the applicant holds an insurance policy for which TU is not a participating provider the applicant must pay for audiology testing in full at the time the service is rendered. TU will provide the appropriate insurance form with proof of payment for the applicant to file for reimbursement by their insurance carrier. If the applicant does not hold insurance, holds an insurance policy that does not pay for audiology services, or is unable to self pay for these services, he/she must apply for a reduction in fees for such services and be approved prior to being scheduled for such evaluations.
- I have completed the Towson University Reduced Fee Application form and attached it and required proof of income to this application.

**Signature of Party in need:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**Signature of club contact:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**Please include a \$25 non-refundable application fee, payable to LASH, and forward to: LASH, Attn: Hearing Aids Program, P.O. Box 821, Bel Air, MD 21014-0821**