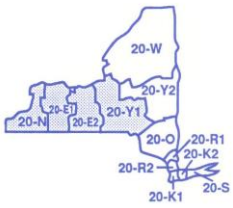
Finger Lakes Region Lions Hearing Foundation, Inc.

607-398-7216

APPLICATION FOR ASSISTANCE

PLEASE PRINT OR TYPE



Name _____ **Age**_____

Street _____ **Home Phone** (_____) _____

City _____, NY **Zip** _____ **Work Phone** (_____) _____

Household Information - *(Give numbers as on IRS forms)*

Number in Household_____ Ages of adults _____ Ages of children _____

Head of Household_____ Spouse _____
Occupation _____ Occupation _____
Employer _____ Employer _____

Medical Insurance Coverage Information – *Check the appropriate Box*

Are you eligible for Medical assistance? **Yes** □ **No** □
Have you applied for Medicaid? **Yes** □ **No** □
Do you have health insurance? **Yes** □ **No** □

Income & Expense Information

Indicate all monthly income (as listed on IRS forms), and all monthly expenses (include ALL household wage earners)

Monthly INCOME

Wages _____
Social Security _____
Pension _____
Unemployment _____
Disability _____
Alimony _____
Interest Income _____
Other: _____

Total Income: _____

Monthly EXPENSES

Mortgage/Rent _____
Food/Clothing _____
Medical _____
Utilities _____
Insurance _____
Loans/Credit Pay _____
Transportation _____
Other _____

Total Expenses: _____

AUTHORIZATION: I hereby authorize the Audiologist or Physician to release any information necessary to process this application and for the purpose of claiming third party insurance coverage, if any. I hereby authorize direct payments to the audiologist, physician or clinic, should there be any third party coverage.

X_____ _____
Signature of Applicant, Parent or Guardian Date Signed

STATEMENT: I fully understand that Finger Lakes Region Lions Hearing Foundation services are limited to persons unable to pay for, or receive from other sources, this assistance. In consideration for such services, I hereby release and discharge all persons rendering such services from any claims that might arise from any services provided.

X _____ _____
Signature of Applicant, Parent or Guardian Date Signed

PLEASE PRINT or TYPE

If this application was received from an **audiological firm**, please have the **Audiologist, ENT or the Medical Practitioner** fill out this ***section***. If the application was received from a Lions Club or from the Finger Lakes Region Lions Hearing Foundation, Inc., it is not necessary to fill out this portion of the form.

Determination and Recommendation: _____

_____

_____

_____

_____ _____ _____

Name of person completing this portion *(Please Print)* Date Phone number

Indicate District if a Lions Club is involved:

N □ E-1 □ E-2 □ Y-1□

Interviewed by: _____
(Please Print)

Street: _____

City: _____Zip _____

Phone: (____) _____ Date of interview: _____

Signature of Interviewer: _____

Remarks: _____

_____

Application Status:

Approved □ Declined □

Returned for more info □

If not approved, state reason:

_____

_____

_____

_____

_____

_____

_____

_____

DISCLOSURE NOTICE

The undersigned applicant for assistance from the Finger Lakes Region Lions Hearing Foundation understands that the personal information requested by the Foundation is to be used solely by the Foundation for the Foundation's purposes only. This information is required to permit the Foundation to evaluate the applicant's financial status to determine if the applicant meets the Foundation's criteria for providing the requested assistance. This information will not be disseminated to any person not connected with the Foundation without the express written consent of the applicant. Please sign below signifying that you understand the purpose for which your personal information is requested.

X _____ _____

Signature of Applicant, Parent or Guardian Date Signed

IMPORTANT NOTICE

This application must be signed in 3 places:

Sign twice on page 1 and once above after the DISCLOSURE NOTICE. **Failing to sign in all places may result in your application being returned or declined.**

Send the completed application to:

Finger Lakes Region
Lions Hearing Foundation, Inc.
P.O. Box 678
Horseheads, NY 14845