WISCONSIN LIONS FOUNDATION, INC.
HEARING AID PROGRAM
Application for Financial Assistance for Hearing Aid(s)

Applicant Name: _____ Date of Birth: _____

Parents Names (when applying for a child): _____
_____

Address: _____ Apt. # _____
City: _____State_____ZIP_____
Daytime Telephone: ( ) ____-_____ Cell Number: ( ) ____-_____

Is the Applicant a **permanent** resident of Wisconsin **(circle one)?** Yes No
How long have you been at your current address? _____

Insurance: Name & policy numbers of any/all health insurance polices: _____
_____

Have you checked if your insurance policy covers hearing aids? (Circle one) Yes No

If you answered yes above, how much will your insurance cover? _____

Have you checked if you qualify for Medicaid? Yes No N/A

Marital Status (circle one): Single Married Widowed Separated

List Names, Ages, and Relationship of **Everyone** in Household: _____
_____

When was the last time your hearing was evaluated?_____
Are you currently working with a hearing professional? (Circle one) Yes No
If yes, please provide following:
Name_____
Address_____
City_____State____ZIP_____ Telephone ( ) ____-_____

----------EMPLOYMENT INFORMATION----------
Parents or Guardians employment information is necessary when applying for a child or dependent

I am currently (circle one): Employed Unemployed Retired Disabled
If employed, please complete the following:
Present Employer: _____
Employer Address: _____
City, State, ZIP _____
Telephone: ( ) ____-_____ Position: _____
Gross Monthly Income $_____ Net Monthly Income $ _____

If married, your spouse is currently: Employed Unemployed Retired Disabled
If employed, please fill out information pertaining to spouse's employment:
Spouse or Name (If applying for child): _____
Present Employer: _____
City, State, ZIP _____
Telephone: ( ) ____-_____ Position: _____
Gross Monthly Income $_____ Net Monthly Income $ _____

Gross Income (before taxes/deductions) & Investments		Monthly Expenses (monthly average)	
Monthly Social Security Benefits	$	Rent/Mortgage **(circle one)**	$
Spouse's Social Security Benefits	$	Utilities	$
Monthly Retirement Pension	$	Food	$
Monthly Food Stamp Benefits	$	Phone	$
Monthly Child Support	$	Medicine/Medical	$
Other Income	$	Car/Transportation	$
	$	Child Care	$
**** Required**		Home Insurance	$
Assets (savings, checking, CD's, etc.)	$	List Charge Cards	$
	$		$
	$	Other expenses	$
Investments (IRA, 401-K, etc.)	$		$
	$	**Total Monthly Expenses**	**$**

**** REQUIRED FINANCIALS:**
Please enclose 3 months of your most current Bank/Financial Statements. ALSO, enclose a copy of proof of income such as last year's Federal and State Tax Returns, and/or Social Security or Disability Benefit Statements, Pension Statements, Latest Paycheck with year-to-date earnings. Proof of financials is **required** for you, your spouse, and other's living in your same household. Financial guidelines are based on **TOTAL** household income. Information received from the applicant remains confidential and is reviewed only by the designated Lion/Lioness members involved in the Hearing Aid Program.

----------**OTHER ASSISTANCE PROGRAMS**----------
Please check each of the following programs you are currently eligible for or have applied for:
_____ Medicaid (Title 19) **Please note - this is not the same as Medicare (Title 18)**
_____ Department of Vocational Rehabilitation (DVR)
_____ Badger Care Plus
_____ Other Please List _____

I understand this application will be reviewed by members of the Lions/Lioness organization in order to determine the applicant's eligibility status. I give my permission to the WLF Hearing Program to release this application to the appropriate members for their review. In addition, I give my permission to have the information provided on this application verified. I certify that all of the information provided is current and accurate to the best of my knowledge. If any information is falsely stated, or if I am working with another assistance program I understand it will disqualify me from the WLF Hearing Aid program.

_____ **- or -** _____
Signature of Applicant Signature of Parent, Guardian, or POA

_____
Date Signed

****Note: All applicants must obtain prior authorization from the WLF Hearing Aid Program before ordering hearing aids**

Please return this form to: WLF Hearing Aid Program 3834 County Road A Rosholt, WI 54473
Phone: (877) 463-6953 (toll-free) Fax: (715) 677-4527

(2018)