Application

(All areas of this application must be completed with either a correct response or an N/A, if the particular request does not apply. Incomplete applications may not be considered.)

Personal Information

First Name	Middle Name	Last Name
Street Address		
City	State	Zip Code
Phone Number	**Social Security Number**	Birth Date

Marital Status: _____Single _____Married Gender: _____Male _____ Female

How many people reside with the applicant? _____ How many people are employed? _____

Household Income: Proof of Income Must Be Sent With This Application Packet

Do you receive Medicaid? Yes _____ No _____
(Not to be confused with Medicare)

Do you receive other Public Assistance? Yes _____ No _____
If yes, what benefits do you receive? _____
How much money do you receive? $ _____

Monthly Household Income (Wages, Social Security, Interest, Other Benefits)	$ _____
Current amount in Savings	$ _____
Current amount in Checking	$ _____
Other Income	$ _____
Total	**$ _____**

Expenses

Insurance Cost ($/month)	$ _____
Prescriptions ($/month)	$ _____
Medical Bills ($/month)	$ _____
Mortgage	$ _____
Car	$ _____
Other Monthly Expenses (Food, Utilities, etc.)	$ _____
Total	**$ _____**

Application

Have you applied for assistance with any other agency to acquire a hearing aid?
Yes ____ No _____
If yes, from whom? _____

Comments regarding any of the aforementioned questions, or other information you may want us to know for further consideration of your financial situation.

_____
_____
_____

Please attach the necessary proof of <u>household income and expenses</u> to this application in order that your request for a hearing aid can be processed in a timely manner. If the necessary documents are not included, the application may be denied.

_____ _____
(Signature) (Date)

_____ _____
(Signature of Person Assisting with Application) (Date)

SHARP Committee Action

Date Received _____ Referred By _____
Date Reviewed _____ Action Taken _____
(Approve/Deny)

Revised 3/18/11 pw

Adult Hearing History

Name _____

Employer _____ Occupation _____

Do you have any dependents? _____ Age(s) _____

When did you first notice a hearing problem? _____

Have you ever had earaches or ear infections? _____

Have you ever had ringing in your ears? _____ Have you ever experienced dizziness? _____

Have you been exposed to loud noises in your occupation? _____

Does any member of your family have a history of hearing loss? _____

If so, who? _____

Have you ever worn a hearing aid? _____ Are you currently wearing a hearing aid(s)?
_____

Which ear? Right _____ Left _____ Make and model _____

How old is the hearing aid(s)? _____

Have you applied for assistance from others to acquire a hearing aid? _____

If yes, from whom and when? _____

Contact person in case of emergency _____

Relationship _____ Phone Number _____

Where did you obtain this application? _____
(facility or individual name)

Which facility would you like to complete the hearing test and fitting of the hearing aid?

St. Rita's Medical Center _____ Lima Memorial Health System_____
Hearing & Balance Center _____ Auglaize Audiology _____