



Date Returned:  
(Office Use)

**CONNECTICUT LIONS DISTRICT 23-A  
HEARING AID BANK  
APPLICATION FOR LIONS CLUB HEARING AID ASSISTANCE**

**Confidential Information**

Sponsoring Lions Club: \_\_\_\_\_ Date: \_\_\_\_\_

Contact Person: \_\_\_\_\_ Telephone: \_\_\_\_\_

*It is important to provide the information requested as completely as possible and in a timely manner.*

\*Recipient's Name: \_\_\_\_\_ \*\*  Child  Adult (check)

Name (If different from recipient): \_\_\_\_\_ Relationship: \_\_\_\_\_

Address: \_\_\_\_\_

Street

Town/City

Zip Code

Telephone: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

\* Person needing hearing aid \*\*Child's school and grade: \_\_\_\_\_

**Recipient's donation towards hearing aid(s) is \$50.00**

Donation family members can make towards hearing aid(s): \$ \_\_\_\_\_

Lions Club share of hearing aid(s) cost \$ \_\_\_\_\_

**Application cannot be processed without the following information:**

Name of Audiologist: \_\_\_\_\_ Phone: \_\_\_\_\_

Date of Last Hearing Test: \_\_\_\_\_

Include a copy of the audiologist's **Audiogram** with this application.

Has applicant used hearing aids before? \_\_\_yes \_\_\_no

Name of medical doctor: \_\_\_\_\_ Phone: \_\_\_\_\_

Address: \_\_\_\_\_  
\_\_\_\_\_

**FINANCIAL INFORMATION**

Employer: \_\_\_\_\_ Gross Pay Per Week: \$ \_\_\_\_\_

Family's total annual income: \$ \_\_\_\_\_

Do you have health insurance coverage?  Yes  No

Insurance Company/HMO/Medicare or Other: \_\_\_\_\_

Are hearing aids covered?  Yes  No

Spouse's Name: \_\_\_\_\_ Work Phone: \_\_\_\_\_

Address (if different from above): \_\_\_\_\_

Employer: \_\_\_\_\_ Gross pay per week: \$ \_\_\_\_\_

List other family members in the home (name, age and relationship to recipient)

\_\_\_\_\_  
\_\_\_\_\_

Have you applied for Title XIX (Medicaid) coverage through the Connecticut, Department of Income Maintenance?  Yes  No

If you applied for Title XIX are you eligible for assistance?  Yes  No

List major monthly expenses, amounts owed (medical, tuition, rent, mortgage, auto, etc.)

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Include any other information that would be helpful in determining eligibility for assistance:

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**RETURN THIS FORM TO:**

**Meryl Aronin 1747 Summer Street Ste. 7 STAMFORD, CT 06905**

**Meryl Aronin, Co-Chair (203) 356-1099**

**Kenny Sachs, Co-Chair (203) 329-8087**