Georgia Lions
Lighthouse Foundation

Better Vision. Better Hearing. ***Better Georgia.***

PEDIATRIC HEARING SERVICES APPLICATION

Building a better tomorrow by
bringing individuals into a
world of sight and sound.

5582 Peachtree Road | Atlanta, GA 30341 | Phone: 404.325.3630 | Fax: 770.406.6558

Application Checklist

The following MUST be submitted for this application to be considered. Failure to include these documents will delay your child's application and increase the time it takes to get your child's hearing aids.

1. Current hearing test (less than 3 months old).
2. Name of Lighthouse-approved Hearing Provider from whom your child will be receiving services
3. Insurance denial or lack of coverage (including PeachCare and Right From the Start Medicaid) of hearing aid and hearing related devices
4. Physician's Medical Condition and Clearance (page 5)
5. Fully completed application and attached documentation

Documentation

- ◊ Georgia birth certificate or Georgia ID of the child/applicant
- ◊ Georgia Driver's License or Georgia ID card from at least one (1) parent or guardian
- ◊ Copy of first page of rental agreement **OR** mortgage statement **OR** letter from home, shelter, or transitional home stating that you live at that location (on letterhead and signed by home/shelter employee) **OR** notarized letter if living with family or friend
- ◊ Last year's tax return

  *if you did not file taxes, you must contact the Lighthouse Foundation for additional appropriate forms of proof of income

Program Service Package

- ◊ 2 digital hearing aids
- ◊ 12 earmolds (bilateral loss); 6 earmolds (unilateral loss)
- ◊ 9 appointments with a pediatric provider
- ◊ 3-year repair warranty

The hearing aid package is **not** free; there will be a copayment based on a sliding scale according to gross household income.

Patient Information

Please print clearly. Keep a copy of this application.

1. Applicant Name: _____

Title First Middle Last Suffix

2. Name of Parent/Guardian: _____

Title First Middle Last Suffix

3. Mailing Address: _____

4. City: _____, Georgia 5. Zip Code:_____

6. County: _____ 7. Child/Applicant's Sex: **M** **F**

8. Child's Social Security Number: ____ - _____-_____ 9. Child's Date of Birth _____ / _____/_____

10. Child/Applicant Race: **White** **African American** **Other** **Hispanic** **Asian**

Primary Parent/Legal Guardian Information

11. Mailing Address (if different from above): _____

12. Home Phone: (____) _____ - _____ Cell Phone: (____) ____ - _____ Work Phone: (____) ____ - _____

13. Email Address : _____ 14. How long have you been a GA resident? _____

15. Are you employed? **Y** **N** 16. If no, are you actively seeking employment? **Y** **N**

17. If you are unemployed, circle all that apply: **Disabled/Receive SSDI** **Unable** **Retired** **Lost Job** **Other**

18. Marital Status: **Married** **Single** **Divorced** **Separated** **Widowed**

Insurance Information

Please list all forms of insurance, including Medicaid, PeachCare, and private insurances. Note that we do not accept Care Credit). Include a copy of your statement of benefits showing whether or not hearing aids are covered.

19. Type of Insurance (i.e. Medicaid, BCBS): _____

20. Primary Parent/Legal Guardian: _____

21. Child/Applicant: _____

State the reason(s) why you cannot afford to purchase hearing aids: _____

How did you hear about the Lighthouse Foundation Hearing Program? _____

Have you or your child applied for and/or received services from the GLLF before? **Y** **N**

Financial Information

List everyone, including yourself, living at your address. Please attach additional household members on separate sheet or list on the back of this page.

Name	Age	Relationship	Dependent (Yes or No)	Source(s) of Income	Amount of Monthly Gross Income
		Child/Applicant			$
					$
					$
					$
					$
Total # of People in Household		**Total # of Dependents in Household**		**Total Monthly Income** (Combined income for all members of household)	$

Parent/Guardian Monthly Expenses

Rent or Mortgage	$
Utilities	$
Food	$
Phone/Cable	$
Credit Cards	$
Insurance (include documentation)	$
Water/Sewage	$
Car Payment	$
Medicine	$
Medical Debt	$

Parent/Guardian Assets

Savings/Checking Accounts	$
Stocks & Bonds (Market Value)	$
Face Value of C.D.s	$
Value of Home/Land/Property	$
Cars/Trucks	$
Other	$

Additional Expenses	Additional Assets

Lighthouse Foundation Approved Hearing Providers

We do our best to partner with hearing professionals in all areas of Georgia. These individuals and practices work with the Lighthouse Foundation hearing program and accept payment from the Lighthouse Foundation on your behalf. They also abide by the guidelines of the Lighthouse Foundation program and agree to provide the services included in your hearing aid package.

For this reason, you **MUST** be a patient of a Lighthouse Foundation-approved hearing provider. A list can be found on our website, www.lionslighthouse.org or by calling 404-325-3630.

What does this mean if your child already has a hearing test? Can you use it?

Maybe. All hearing tests must be current; that means it must be 3 months old or less. If your child's hearing test does not come from a Lighthouse-approved provider, our Lighthouse providers *may* require your child to get a new test from them before he/she can be their patient. If your child has a current test you wish to use, you will need to ask the Lighthouse provider if he/she will accept it.

How do you find a Lighthouse Foundation-approved hearing provider?

You can find a current list of providers at www.lionslighthouse.org, or you can call the Lighthouse Foundation at 404-325-3630 to request a list.

1. Choose a Lighthouse Provider from the provided list.

2. Call the Provider you have chosen. Tell them that you are applying to the Georgia Lions Lighthouse Foundation for pediatric hearing aid assistance and you need a Lighthouse Foundation-approved provider.

    * If your child **has** a hearing test that is less than 3 months old, ask them if they will accept it.

    * If you **do not have** a hearing test, tell them your child will need one.

3. Ask the Provider if they are willing to accept your child as a new patient. If the provider agrees, you will see this provider for your Lighthouse Foundation-approved hearing appointments.

Write the name of your Lighthouse Foundation-approved hearing provider here:

_____

Medical Condition & Clearance

Child's Primary Diagnosis: _____

I recommend the following treatment(s): _____

Are there any medical barriers to treatment? Yes No

If yes, please list: _____

I certify that _____ (applicant name) was medically examined on ___/____/___ and may be considered a candidate for hearing aid use. *Must be signed and dated by a licensed physician (M.D.).

_____ ____/____/____

Signature of Physician Date

_____ _____

Name of Physician (Please Print) Name of Physician's Practice

Provider Recommendation

This section must be completed by the hearing professional who performed the hearing test. You must include a copy of that current hearing test (audiogram).

The Lighthouse Foundation does not pay for hearing tests.

Business Name: _____

Name and Title of Hearing Professional: _____

Phone Number: _____ Fax Number: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Please specify degree of hearing loss:

Mild Moderate Moderately Severe Severe Profound

Circle the type of hearing aids recommended:

Right Ear:	None	RIC/BTE	ITE	BICROS	BAHA (soft band)
Left Ear:	None	RIC/BTE	ITE	BICROS	BAHA (soft band)

Is this facility a Lighthouse Provider? **Yes** **No**

If no, are you interested in becoming a Lighthouse Provider? **Yes** **No**

Contact us at 404.325.3630 x305 or visit www.lionslighthouse.org for more information.

Lighthouse Statement

Please Read and Sign This Statement:. This MUST be signed by all patients.

"I fully understand Lighthouse services are limited to legal GA residents unable to pay for, or receive from other sources, this assistance. In consideration of these services, I release and discharge all persons rendering such services from any claims I may have arising from services rendered. I am aware that the Lighthouse will not pay for any hearing aids billed to me prior to approval of this application. I also understand my application may be reviewed by a Lions Club, Lighthouse Providers, and/or the Lighthouse staff.

All Information on and attached to this application is true and correct to the best of my knowledge. I also understand that the Lighthouse Foundation has the right to refuse service to any applicant."

_____ _____

Name of Applicant Date

_____ _____

Parent/Guardian Date

Authorization of Information/Emergency Contact

EVERYONE MUST SIGN AND DATE THE BOTTOM OF THIS PAGE.

Please list an emergency contact for your child. If you grant us permission to speak with this person about your child's services, please check the box on the right. If you want us to speak only with you, the listed parent or guardian, do not check the box to the right.

Emergency Contact

1. Name _____
2. Relationship to Applicant: _____
3. Phone: _____
4. Address: _____
5. City _____ 6. State _____ 7. Zip Code _____

◊ Permission to speak with listed contact about your child's services

I understand that the Health Insurance Portability & Accountability Act (HIPPA) Privacy Rule does not protect the privacy of information if re-disclosed, and therefore request that all information obtained by this person or agency be held strictly confidential and not be further released by the recipient. I further understand that my eligibility for Lighthouse services is not conditioned upon my provision of this authorization. I intend for this document to be a valid authorization conforming to all requirements of the Privacy Rule and understand that my authorization will remain in effect for:

Please check how long you give us permission to speak with the above-listed individual:

◊ Ninety (90) days

◊ One (1) year

◊ Until this specified expiration date: _____/_____/_____

◊ The period necessary to complete all transactions on matters related to services provided to me. I understand that unless otherwise limited by state or federal regulation, and except to the extent that action has been taken based upon it, I may withdraw this authorization at any time.

_____ _____

Name of Applicant **Date**

_____ _____

Signature of Parent/Guardian **Date**

Hearing Program Survey. Please circle or place a check mark by your choice.

If you are a parent/guardian filling out this survey for a dependent child, please provide answers from the perspective of the child.

APPLICANT NAME: _____ DATE: _____

1. What is your age? a. 0-3 b. 4-8 c. 11-15 d. 16-19
2. Are you a first time hearing aid user? Yes No
3. Have you received hearing aid(s) from the Lighthouse Foundation before? Yes No
4. How long have you experienced hearing loss?
   a. less than 5 years
   b. 5 to 10 year
   c. 10 to 15 years
   d. 15+ years
5. How often do you experience the following symptoms? For each choose ONLY ONE of the options:

	Very Frequently	Frequently	Occasionally	Rarely	Never
Tinnitus (Ringing or roaring in the ears)					
Balance Issues					
Vertigo/dizziness					

6. At the present time, would you say your overall hearing is excellent, good, fair, poor, or very poor. You may also describe your overall hearing in the comment section.
   a. Excellent
   b. Good
   c. Fair
   d. Poor
   e. Very Poor
   f. Comment:_____
7. Are you a student? Yes No

   If you answered yes, with your current hearing, how well are you able to do the following activities? For each activity choose ONLY ONE of the following options: Very well, Well, Difficult, Very Difficult, or N/A

	Very Well	Well	Difficult	Very Difficult	N/A
Communicate with teacher and classmates					
Listen to audio presentations in the class-room/lecture hall					
Communicate with others in the library					
Complete assignments					
Participate in class discussions					

10. How were you referred to the Lighthouse Foundation?
    a. DFACS, DPH, DCH
    b. Let Georgia Hear
    c. Private Insurance
    d. Medicaid/Medicare Specialist
    e. Newspaper Article
    g. CHOA/Pediatric ENT of Atlanta
    h. Lions Club
    i. Audiologist/Hearing Aid Dispenser
    j. Website
    f. Other:_____