Pediatric Hearing Services Application

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


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.

<table>
<thead>
<tr>
<th>Name</th>
<th>Age</th>
<th>Relationship</th>
<th>Dependent (Yes or No)</th>
<th>Source(s) of Income</th>
<th>Amount of Monthly Gross Income</th>
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<td>Child/ Applicant</td>
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| 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.

“[Full text of the statement is provided, covering topics such as understanding Lighthouse services, releasing liability, application review, and the truthfulness of information provided.]

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: __________________________________________

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 years
   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:

<table>
<thead>
<tr>
<th>Symptoms</th>
<th>Very Frequently</th>
<th>Frequently</th>
<th>Occasionally</th>
<th>Rarely</th>
<th>Never</th>
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<tbody>
<tr>
<td>Tinnitus (Ringing or roaring in the ears)</td>
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<td>Balance Issues</td>
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<tr>
<td>Vertigo/dizziness</td>
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</table>

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

<table>
<thead>
<tr>
<th>Activities</th>
<th>Very Well</th>
<th>Well</th>
<th>Difficult</th>
<th>Very Difficult</th>
<th>N/A</th>
</tr>
</thead>
<tbody>
<tr>
<td>Communicate with teacher and classmates</td>
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<tr>
<td>Listen to audio presentations in the classroom/lecture hall</td>
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<td>Communicate with others in the library</td>
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<td>Complete assignments</td>
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<td>Participate in class discussions</td>
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</table>

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
   f. Other:____________________________________
   g. CHOA/Pediatric ENT of Atlanta
   h. Lions Club
   i. Audiologist/Hearing Aid Dispenser
   j. Website