



# Lions of Illinois Foundation

## SOCIAL SERVICES REQUEST FORM

### HEARING AIDS

#### Applicant Information

Today's Date \_\_\_\_\_  
Date of Birth \_\_\_\_\_

Name \_\_\_\_\_  
Address \_\_\_\_\_ Apt # \_\_\_\_\_  
City \_\_\_\_\_ IL. Zip \_\_\_\_\_  
Home Phone# \_\_\_\_\_ Work # \_\_\_\_\_ Sex \_\_\_\_\_ Male \_\_\_\_\_ Female

Assistance Requested: Hearing Test (Adults) \_\_\_\_\_ Hearing Aid (Adults) \_\_\_\_\_ BOTH \_\_\_\_\_

Other (hearing related) \_\_\_\_\_

Marital Status: \_\_\_\_\_ Number of Dependents \_\_\_\_\_ Ages \_\_\_\_\_

Are you currently: \_\_\_\_\_ Working/state occupation \_\_\_\_\_  
Employer Name \_\_\_\_\_  
Address \_\_\_\_\_  
Phone # \_\_\_\_\_  
Disabled/nature of disability \_\_\_\_\_  
Student: \_\_\_\_\_ Full Time \_\_\_\_\_ Part Time

#### \*TOTAL MONTHLY INCOME

Wages *or* General Assist. \$ \_\_\_\_\_  
Other family income \$ \_\_\_\_\_  
Pension \$ \_\_\_\_\_  
Unemployment \$ \_\_\_\_\_  
Social Security/SSI \$ \_\_\_\_\_  
Food Stamps \$ \_\_\_\_\_  
Other \$ \_\_\_\_\_

**Total** \$ \_\_\_\_\_

#### \*TOTAL MONTHLY EXPENSES

Rent/Mortgage \$ \_\_\_\_\_  
Utilities \$ \_\_\_\_\_  
Cell phone \$ \_\_\_\_\_  
Medical \$ \_\_\_\_\_  
Clothing \$ \_\_\_\_\_  
Food \$ \_\_\_\_\_  
Other \$ \_\_\_\_\_

**Total** \$ \_\_\_\_\_

Do you have: \_\_\_\_\_ Medical Insurance, Insurance Co. Name: \_\_\_\_\_

**IF YOU HAVE INSURANCE YOU MUST OBTAIN MEDICAL CLEARANCE AND AN AUDIOGRAM (HEARING TEST) BEFORE COMING TO LIONS FOR ASSISTANCE. SEND A COPY OF THOSE FORMS WITH YOUR REQUEST.**

Public Aid: \_\_\_\_\_ Yes \_\_\_\_\_ No

Can you share in costs: \_\_\_\_\_ Yes, how much \$ \_\_\_\_\_ NO \_\_\_\_\_

The above information is true to the best of my knowledge.

(must be signed by adult requesting assistance.)

**\*\* If you already have a prescription of eyeglasses, medical clearance or audiogram please send a copy with this completed application.**

**\*\*\* This process takes approximately 12 weeks for assistance.**

**\*\*\* An incomplete application will not be processed. Income and expenses must be listed. \* Zero amounts must be explained on reverse side.**

**Please return to: LIF 700 N. Peace Road, Suite B, DeKalb, IL 60115 ATTN: SOCIAL SERVICES**

To find your local club: [www.lionsclubs.org](http://www.lionsclubs.org)



# Lions of Illinois Foundation

## *Social Services*

### CONSENT FOR SERVICES

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I, \_\_\_\_\_, understand that if I am selected as a candidate by my local Lions Club, prior to receiving any payment assistance, I must authorize my diagnostic and treating healthcare providers to release certain personally identifiable health care information (PHI) about me to the Lions of Illinois Foundation who will be processing payment for my services and devices on behalf of my local Lions Club.

I also understand that if I fail to authorize such release of my PHI, that payment may be delayed or denied, and services may be delayed. I consent to be contacted by the Lions of Illinois Foundation if there is an issue with my authorization and agree to complete such paperwork as the Lions of Illinois Foundation and/or my healthcare provider may require to give effect to this authorization.

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Signature

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Date

700 N Peace Road, Suite B, DeKalb, IL 60115

Phone 815-756-5633—Fax 815-748-9087

[Lionsofillinoisfoundation.org](http://Lionsofillinoisfoundation.org)

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