Lions Sight & Hearing Foundation

Phone: 602-954-1723 Fax: 602-954-1768

Sounds Abound Program: Request for assistance

3427 N 32nd Street
Phoenix, AZ 85018

office use only
*Date received*_____
*Case number*_____

Applicant:_____Sex; Male / Female
(*Name; please print clearly)*

Address;_____Email Address:_____

City; _____Zip code; _____Phone; (___)_____

Date of Birth; _____Age;_____.

Contact Person; _____*Phone; (___)*_____.

*Address;*_____

City; _____*Zipcode;* _____*Cell Phone; (___)*_____

Number of persons in Household; Adults ____Children _____How did you hear about us?_____

What is your Ethnicity? ☐ White/Caucasian _____ ☐ Hispanic _____ ☐ African American/Black_____

☐ Native American _____ ☐ Pacific Islander_____ ☐ Other _____

Disclaimer: No person shall be discriminated against because of race, religion, gender, sexual orientation, creed, age, color, marital status, physical handicap or disability, national origin, or veteran status

Income: Husband $_____Wife $_____other $_____
Please list ALL other income to include everyone in the household
Example - SSI, SS, Food stamps, ADC, Interest, Dividends, retirement Funds, child support, etc.

TOTAL MONTHLY INCOME (please total all of the above) $_____

Please List ALL monthly expenses;

Rent / Mortgage Payment	$
Utilities (phone, gas, water, electric)	$
Food	$
Insurance (Auto, Health Life etc)	$
Installments Payments	
Auto (include final date)_____	$_____
Loans / credit cards _____	$_____

TOTAL MONTHLY EXPENSES **$**_____

If you have NO income, please attach a separate sheet explaining your living arrangements.

See over – Please answer all questions and SIGN the application.

Insurance; AHCCCS, Medicare _____

Do you currently wear a hearing aid? YES_____NO____
If "yes"; are you willing to donate your old one? YES_____NO____
Do you have your hearing test results? YES_____ NO____
Which ear(s) do you require a hearing aid for?.....Rt___Lt___Both___

***Please attach copies of hearing test results & any other information regarding your hearing condition**

Important: You must enclose the first two (2) pages of parents Last Year's Federal Income Tax return if you filed. If you did not file, attach copies of proof of income (W2, check pay stubs etc).

The Lions Sight & Hearing Foundation has not granted any authority, express or implied, to any person, organization, or government agency, including, but not limited to, any person, referral organization, Lions Club or Physician from whom you may have obtained this request for assistance, to act on behalf of, to act on behalf of or to otherwise bind the Lions Sight & Hearing Foundation in any manner whatsoever. Neither this application form, nor your receipt of this application from any such source is a representation from the Lions Sight & Hearing Foundation of any authority, actual or apparent, in such source all such expressions authority are hereby disclaimed. You should direct any questions regarding the services available through the Lions Sight & Hearing Foundation, eligibility for such services, the cost of such services and this *request for assistance* directly to the Lions Sight & Hearing Foundation at the address and/or phone number set forth on this form. There is no application fee associated with the submittal to and review by the Lions Sight & Hearing Foundation.

Release;

I for myself, my heirs, personal representatives, executors, administrators, and assigns, and on behalf of the patient if the patient is other than myself and I am the responsible party for the patient, waive, release and forever discharge the Lions Sight & Hearing Foundation and the Lions Clubs of Arizona, their officers, directors, agents, representatives, successors and all co-operating entities and individuals from all claims, losses, damages which now exist or may hereafter arise in connection with my and/or the patients participation with any services rendered through Lions Sight & Hearing Foundation.

To the best of my knowledge, I represent the information on this form to be correct. I acknowledge and understand this release thoroughly and authorize any service provider contracted by the Lions Sight & Hearing Foundation to release to the Lions Sight & Hearing Foundation any information required.

I do hereby give the LIONS SIGHT & HEARING FOUNDATION permission to use my picture in any publicity brochure that is deemed appropriate by the Foundation.

Signature_____ Date; _____

For patients / applicants under 18 years of age;

Any patient under 18 years old **MUST** have an authorization before being accepted. Responsible person has read and understands *request for assistance*. I am willing to accept the services provided by the Lions Sight & Hearing Foundation for this minor child.

I do hereby give the LIONS SIGHT & HEARING FOUNDATION permission to use my daughter/son picture in any publicity brochure that is deemed appropriate by the Foundation.

After you have read all of this form please sign and date below:

Signature;_____ Date; _____

Relationship to applicant; _____

FALSE STATEMENTS ARE GROUNDS FOR REFUSAL OF BENEFITS

(Office use only);
If referred by a Lions Club _____ *Date* _____
(Name of club)

Recommended by _____ *Phone* _____
(Name of referring Lion)

Address _____ *City* _____ *Zip* _____

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INSTRUCTIONS FOR SOUNDS ABOUND HEARING CARE PROGRAM

Enclosed you will find the application for Sounds Abound hearing care program. Please complete all of the forms and return them with the information requested so we can determine eligibility. Please refer to the Eligibility Guidelines for more information regarding eligibility.

Please submit the following information:

1. **Proof of legal residence** such as a copy of your AZ driver's license or AZ identification card
2. **Proof of parents income** (e.g. SSI, SS, Food Stamps, ADC, Interest, Dividends, retirement funds, etc.) If you are required to file income taxes, please submit a copy of the first two pages of your current taxes.

Once we receive all the information requested, your application will be reviewed by our Hearing Committee in the order it is received.

Lions Sight & Hearing Foundation
Hearing Committee

LIONS SIGHT & HEARING FOUNDATION
3427 N. 32nd Street
Phoenix, AZ 85018
Phone: (602) 954-1723 FAX: (602) 954-1768
ls-hf .org

SOUNDS ABOUND PROGRAM ELIGIBILITY GUIDELINES

WHO IS ELIGIBLE? In order to be considered for assistance you are required to fill out an application and meet the following criteria:

- You must be able to provide proof that you are a legal Arizona resident and provide a copy of your AZ license or AZ identification. You must also have been a resident of AZ for 6 months or longer.

- You must provide a copy of the first two pages of last year's Federal Income Tax if you are required to file. If you do not file taxes, you must provide other proof as requested by the Foundation.

- Your Total Household income must not exceed amount (200%) listed on Poverty Level Guidelines. Household income includes **anyone who receives income in your household.**

- You must provide proof of health insurance of any type if requested by the Foundation.

The obvious lifestyle of the applicant is taken into consideration and may include an interview with Office Staff, Director, or Lions Club member.

Restoring vision and hearing for over 30 years in Arizona.

Poverty Income Guidelines

# IN HOUSEHOLD	ANNUAL INCOME	MONTHLY INCOME	200% NEW
1	18,210	1,518	2,023
2	24,690	2,058	2,743
3	31,170	2,598	3,463
4	37,650	3,138	4,183
5	44,130	3,678	4,903
6	50,610	4,218	5,623
7	57,090	4,758	6,343
8	63,570	5,298	7,063

HIPAA Authorization Release Form

Authorization for Use or Disclosure of Protected Health Information
(Required by the Health Insurance Portability and Accountability Act, 45 C.F.R.Parts 160 and 164)

1. Authorization

I authorize LIONS SIGHT & HEARING FOUNDATION (healthcare provider) to use and disclose the protected health information described below to _____ (individual seeking the information).

2. Extent of Authorization

a. □ I authorize the release of my complete health record (including records relating to mental healthcare, communicable diseases, HIV or AIDS, and treatment of alcohol or drug abuse).

b. □ I authorize the release of my complete health record with the exception of the following information:
□ Mental health records
□ Communicable diseases (including HIV and AIDS)
□ Alcohol/drug abuse treatment
□ Other (please specify): _____

3. This medical information may be used by the person I authorize to receive this information for medical treatment or consultation, billing or claims payment, or other purposes as I may direct.

4. This authorization shall be in force and effect until _____ (date or event), at which time this authorization expires.

5. I understand that I have the right to revoke this authorization, in writing, at any time. I understand that a revocation is not effective to the extent that any person or entity has already acted in reliance on my authorization or if my authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest a claim.

6. I understand that my treatment, payment, enrollment, or eligibility for benefits will not be conditioned on whether I sign this authorization.

7. I understand that information used or disclosed pursuant to this authorization may be disclosed by the recipient and may no longer be protected by federal or state law.

X Date:_____

X _____
Signature

X _____
Printed Name