WISCONSIN LIONS FOUNDATION, INC. HEARING AID PROGRAM

Application for Financial Assistance for Hearing Aid(s)

pplicant Name: Date of Birth:	
Parents Names (when applying for	r a child):
Address:	Δnt #
City:	Apt. # StateZIP
Daytime Telephone: ()	State
	dent of Wisconsin (circle one)? Yes No current address?
	ers of any/all health insurance polices:
Have you checked if your insurance	ce policy covers hearing aids? (Circle one) Yes No
If you answered yes above, how m	nuch will your insurance cover?
Have you checked if you qualify for	for Medicaid? Yes No N/A
Marital Status (circle one): Sing	gle Married Widowed Separated
•	ip of Everyone in Household:
When was the last time your hearing. Are you currently working with a last fyes, please provide following: NameAddress	hearing professional? (Circle one) Yes No
CitySta	ateZIP Telephone ()
Parents or Guardians employed I am currently (circle one): Employed, please complete the Present Employer:	e following:
Employer Address:	
City, State, ZIP	
Telephone: ()	Position:
Gross Monthly Income \$	Net Monthly Income \$
If employed, please fill out information Spouse or Name (If applying for conferent Employer: City, State, ZIP	ntly: Employed Unemployed Retired Disabled mation pertaining to spouse's employment: child):
Telephone: ()	Position: Net Monthly Income \$
Gross Monthly Income \$	Net Monthly Income \$

Gross Income (before taxes/deductions) & Investments		Monthly Expenses (monthly average)	
Monthly Social Security Benefits	\$	Rent/Mortgage (circle one)	\$
Spouse's Social Security Benefits	\$	Utilities	\$
Monthly Retirement Pension	\$	Food	\$
Monthly Food Stamp Benefits	\$	Phone	\$
Monthly Child Support	\$	Medicine/Medical	\$
Other Income	\$	Car/Transportation	\$
	\$	Child Care	\$
** Required		Home Insurance	\$
Assets (savings, checking, CD's, etc.)	\$	List Charge Cards	\$
	\$		\$
	\$	Other expenses	\$
Investments (IRA, 401-K, etc.)	\$		\$
	\$	Total Monthly Expenses	\$

** REQUIRED FINANCIALS:

Please enclose 3 months of your most current Bank/Financial Statements. ALSO, enclose a copy of proof of income such as last year's Federal and State Tax Returns, and/or Social Security or Disability Benefit Statements, Pension Statements, Latest Paycheck with year-to-date earnings. Proof of financials is **required** for you, your spouse, and other's living in your same household. Financial guidelines are based on **TOTAL** household income. Information received from the applicant remains confidential and is reviewed only by the designated Lion/Lioness members involved in the Hearing Aid Program.

OTHER A	SSISTANCE PROGRAMS
Please check each of the following prog	grams you are currently eligible for or have applied for:
Medicaid (Title 19) Please no	ote - this is not the same as Medicare (Title 18)
Department of Vocational Reh	abilitation (DVR)
Badger Care Plus	
Other Please List	
appropriate members for their review application verified. I certify that all	ny permission to the WLF Hearing Program to release this application to the w. In addition, I give my permission to have the information provided on this of the information provided is current and accurate to the best of my knowledge. It I am working with another assistance program I understand it will disqualify me to the best of the best of my knowledge. It is a working with another assistance program I understand it will disqualify me to the best of the b
G: (A 1)	- or
Signature of Applicant Date Signed	- or Signature of Parent, Guardian, or POA

**Note: All applicants must obtain prior authorization from the WLF Hearing Aid Program <u>before</u> ordering hearing aids

Please return this form to: WLF Hearing Aid Program 3834 County Road A Rosholt, WI 54473 Phone: (877) 463-6953 (toll-free) Fax: (715) 677-4527