



# LIONS OF MICHIGAN FOUNDATION

## Robert Mathog Lions Hearing Centers

5730 Executive Drive  
Lansing, Michigan 48911

517-887-6640 – [www.lhcmi.org](http://www.lhcmi.org) – [info@lhcmi.org](mailto:info@lhcmi.org)

FOR OFFICE USE ONLY	
DATE RECEIVED	
DETERMINATION	

### HEARING AID ASSISTANCE APPLICATION

The Lions of Michigan Foundation and our Lions Hearing Centers provide quality affordable hearing aids for financially stressed Michigan residents through partnerships with hearing aid suppliers, hearing professionals and other charities and community service organizations. Applications for hearing aid assistance are prioritized based on the overall financial and medical need of the applicant, and applicants with annual household incomes up to 325% of Federal Poverty Guidelines (\$41,570.00 for a single person household) may qualify for hearing aid assistance. For current Federal Poverty Guidelines, visit: <https://aspe.hhs.gov/poverty-guidelines>.

All Applicants must be legal Michigan residents and, when possible, applicants should be sponsored by a Michigan Lions Club or Lions District that can help in the application process and may provide additional resources and services.

#### SPONSOR:

Lions Club/District: \_\_\_\_\_ Representative: \_\_\_\_\_  
Email: \_\_\_\_\_ Phone #: \_\_\_\_\_

#### APPLICANT:

Mr. \_\_\_ Ms. \_\_\_ First Name: \_\_\_\_\_ Last Name: \_\_\_\_\_  
Address/City/Zip: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_  
Social Security #: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ Birthdate: \_\_\_\_\_  
Email: \_\_\_\_\_ Phone #: \_\_\_\_\_

#### APPLICANT'S PARENT – LEGAL GUARDIAN – POWER OF ATTORNEY OR APPOINTED REPRESENTATIVE:

Mr. \_\_\_ Ms. \_\_\_ First Name: \_\_\_\_\_ Last Name: \_\_\_\_\_  
Email: \_\_\_\_\_ Phone #: \_\_\_\_\_

#### APPLICANT'S PERSONAL & MEDICAL INFORMATION:

Is the applicant a legal Michigan resident? Yes \_\_\_ No \_\_\_. [If yes, a photocopy of the applicant's Michigan Driver's License or Michigan Identification Card must be submitted with the application.](#)

Is the applicant a United States military veteran? Yes \_\_\_ No \_\_\_. [If yes, a photocopy of the applicant's Veterans Administration Denial Letter for hearing aids must be submitted with the application.](#)

Has the applicant received hearing aids from the Lions of Michigan Foundation or any of our Robert Mathog Lions Hearing Centers in the past 4 years? Yes \_\_\_ No \_\_\_

Does the applicant currently use hearing aids? Yes \_\_\_ No \_\_\_ Right Ear: \_\_\_ Left Ear: \_\_\_

If the applicant currently uses hearing aids, please indicate the age of the hearing aids and describe any problems that the applicant is experiencing with the aids: \_\_\_\_\_  
\_\_\_\_\_

Has the applicant had a hearing test in the past 6 months? Yes\_\_\_\_ No\_\_\_\_

Has the applicant received a medical clearance for hearing aids? Yes\_\_\_\_ No\_\_\_\_

**APPLICANT'S HOUSEHOLD STRUCTURE:**

Number of adults in the household: \_\_\_\_\_ Number of children in the household: \_\_\_\_\_

Name: \_\_\_\_\_ Age: \_\_\_\_\_ Relationship: \_\_\_\_\_  
Name: \_\_\_\_\_ Age: \_\_\_\_\_ Relationship: \_\_\_\_\_  
Name: \_\_\_\_\_ Age: \_\_\_\_\_ Relationship: \_\_\_\_\_  
Name: \_\_\_\_\_ Age: \_\_\_\_\_ Relationship: \_\_\_\_\_  
Name: \_\_\_\_\_ Age: \_\_\_\_\_ Relationship: \_\_\_\_\_  
Name: \_\_\_\_\_ Age: \_\_\_\_\_ Relationship: \_\_\_\_\_

**APPLICANT'S PROOF OF INCOME:**

The annual income for each household member must be documented. Applications will not be processed without a proof of income.

<b>Annual Household Income</b>	<b>Amount/Monthly</b>	<b>Amount/Yearly</b>
Wages & Tips:		
Business Income:		
Social Security Benefits:		
Government/Public Assistance (Food, Housing & Cash):		
Pension Income:		
Disability Income & Workers Compensation:		
Other Income (Attach Schedule):		

Did the applicant file a federal income tax return for the prior year? Yes\_\_\_\_ No\_\_\_\_. [If yes, a photocopy of the applicant's federal income tax return must be submitted with the application. If no, an alternative proof of income \(Social Security Benefits Statement, SSI Benefits Statement and/or Pension Benefits Statement\) must be submitted with the application.](#)

**APPLICANT'S ASSET VERIFICATION:**

The combined assets of each household member must be documented.

<b>Assets</b>	<b>Financial Institution(s)</b>	<b>Source</b>	<b>Acct. Balance</b>
Savings:			
401k - IRA:			
Stocks/Bonds/CDs:			
Home (Principal):			

**APPLICANT'S HEALTH INSURANCE COVERAGE:**

All applicants must include a photocopy of their health insurance cards (front and back). [Applicants with Medicaid must submit a Medicaid Denial Letter for hearing aids or verification of their Medicaid Spenddown.](#)

None     Medicaid     Medicare     County Health Plan     Private Insurance

List Any Coverage For Hearing Aids & Audiology Services:

\_\_\_\_\_

\_\_\_\_\_

**Please check the corresponding box for EACH required/requested attachment submitted**

- Photocopy of applicant's proof of Michigan residency (Michigan Driver's License or Identification Card).
- Photocopy of applicant's proof of income (Federal Income Tax Return, Social Security Benefits Statement, and/or Pension Benefits Statement).
- Photocopy of applicant's proof of medical need (Audiogram/Hearing Test).
- Photocopy of applicant's health insurance cards, including Medicaid and Medicare.
- Photocopy of applicant's denial letter from Medicaid or Medicaid Spenddown verification letter.
- Photocopy of applicant's denial letter(s) from the U.S. Veterans Administration and/or Michigan Rehabilitation Services.

**APPLICANT'S MEDICAL & FINANCIAL INFORMATION RELEASE & UNDERSTANDING:**

I, \_\_\_\_\_, understand that if my application for hearing aid assistance is approved, the Lions of Michigan Foundation's Lions Hearing Centers will only provide hearing aids from its approved hearing aid suppliers, and I may have a co-pay for my hearing aids and the fees charged by an audiologist or hearing professional for selecting, fitting and dispensing my hearing aids. I further understand that any co-pay for my hearing aids must be paid before the hearing aids are ordered, and co-pays will be based on my annual household income, accumulated assets and other relevant information.

I understand that any hearing aids provided are for my personal use only, and **the United States Food and Drug Administration recommends that I obtain a medical examination and medical clearance before acquiring and using hearing aids.** I further understand that if my application is approved in whole or in part, the Lions of Michigan Foundation and its Lions Hearing Centers may elect to identify me in its financial and reporting records and promotional materials by my first or last name, my home community, and the general nature and dollar value of the medical service provided.

I hereby authorize all medical care providers treating my stated medical condition related to this application to release protected health and medical information to the Lions of Michigan Foundation and its partnering hearing aid suppliers and hearing professionals, and **I authorize the use of the electronic transmittal of the information contained in my application for my case review and communication with all involved parties.**

I release the staff, officers, and representatives of the health care providers, the Lions of Michigan Foundation, the sponsoring Lions Club and District, and all other organizations listed on this application from all legal liabilities relative to the use and release of the information requested on this application and contained herein, **including the electronic transmittal of the information**, and I attest that, to my knowledge, all information on this application is accurate.

\_\_\_\_\_  
Signature of Applicant or Parent/Guardian/Power of Attorney

\_\_\_\_\_  
Date