

**CENTRAL VIRGINIA LIONS HEARING AID BANK (CVLHAB)**

1512 Willow Lawn Drive,  
Richmond, VA 23230  
(804)-545-5937

**APPLICATION FOR ASSISTANCE**

**INSTRUCTIONS:** This is a three section form. The first section requests information on the applicant/verification of need and should be completed by the applicant or the applicant's family. The second section determines hearing loss and the gain to be provided by the hearing aid and must be completed by an Audiologist or a Hearing Aid Specialist. Section three must be completed by an ENT or your primary physician. If you have already had your hearing test, take it to the provider who performed your test.

If you do not know who to go to for the test, call CVLHAB at (804)-545-5937.

**When both sides are complete, send the form to CVLHAB at the above address.**

**SECTION I - APPLICANT INFORMATION/VERIFICATION OF NEED**

Applicant Name: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ Zip Code: \_\_\_\_\_ Phone: \_\_\_\_\_

Birth Date: \_\_\_\_\_ Number of Persons in Household: \_\_\_\_\_

Is Applicant Head of Household? \_\_\_\_\_ Social Security No.: \_\_\_\_\_

Is the Applicant Working? \_\_\_\_\_ If Yes, Where? \_\_\_\_\_

Family Annual Gross Income: \$ \_\_\_\_\_ Source of Income: \_\_\_\_\_

Medical Insurance/Medicare/Medicaid Coverage? \_\_\_\_\_ Yes \_\_\_\_\_ No

If Yes, Which Type? \_\_\_\_\_

Policy Number: \_\_\_\_\_ Provider Phone No. \_\_\_\_\_

What kinds of hearing problems you are having? \_\_\_\_\_

What other funding sources have been explored? Can these fund some or all of the request?

Is there any other information CVLHAB should know in considering this request?

I certify that the information above is true. I understand/agree that CVLHAB has the right to verify any information submitted.

Signed \_\_\_\_\_ Date \_\_\_\_\_

## SECTION II - HEARING ANALYSIS

(TO BE COMPLETED BY THE HEARING SPECIALIST PRIOR TO MEDICAL CLEARANCE)

Is Applicant a Current Hearing Aid User? \_\_\_\_\_

If Yes, What Model/type of hearing Aid? \_\_\_\_\_

Hearing Test:

Threshold at 1000 Hz (in dBHTL's): Left: \_\_\_\_\_ Right: \_\_\_\_\_

Threshold at 2000 Hz (in dBHTL's): Left: \_\_\_\_\_ Right: \_\_\_\_\_

Threshold at 3000 Hz (in dBHTL's): Left: \_\_\_\_\_ Right: \_\_\_\_\_

Threshold at 4000 Hz (in dBHTL's): Left: \_\_\_\_\_ Right: \_\_\_\_\_

What is the Unaided Discrimination at 45 dB? \_\_\_\_\_

What is the Unaided Discrimination at Applicant MCL? \_\_\_\_\_

Which ear to be fit? \_\_\_\_\_

### Categorization of Hearing Aid Need:

Would you classify the hearing loss as:  Mild  Moderate  Severe

Would Tone Control be Needed on the Aid:  Yes  No

Would Power Control be Needed on the Aid:  Yes  No

In your opinion, does this potential recipient meet the protocol established by CVLHAB?  Yes  No

**TO THE PROVIDER: BY PARTICIPATING IN THE CVLHAB PROGRAM, YOU AGREE TO TREAT THE APPLICANT AS A NORMAL FEE PAYING PATIENT WHILE AMENDING YOUR FEE SCHEDULE TO BE WITHIN THE GUIDELINES ESTABLISHED FOR PLACING DONATED AIDS BY CVLHAB.**

Provider Signature \_\_\_\_\_ Date \_\_\_\_\_

Please staple your business card here, or complete your office's full name and address/phone number

Thank you for your assistance!

## SECTION III - MEDICAL CLEARANCE

**ONCE YOU HAVE OBTAINED A HEARING TEST, A MEDICAL CLEARANCE MUST BE SIGNED BY AN ENT OR YOUR PRIMARY PHYSICIAN**

### MEDICAL CLEARANCE (Must Be Completed By A Medical Doctor)

The Applicant, \_\_\_\_\_, has been evaluated and determined not to have any medical contraindications for the use of a hearing aid(s).

Physician Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Print Physician's Name: \_\_\_\_\_