Lions of Illinois Social Service Department
RECONDITIONED HEARING AID APPROVAL FORM
2254 Oakland Dr., Sycamore, IL 60178: Fax: (815)748-9087

Date: _____

Name of Patient: _____ **Date of Birth:** _____ **Age:**_____

Address: _____ **City:**_____ **Zip:**_____

Home #:_____ **Cell #:**_____

Please indicate below, the services that your club will provide

MEDICAL CLEARANCE
☐ Client will provide Medical Clearance
☐ Our club will pay the cost of the medical clearance
☐ Medical clearance is enclosed.
☐ Client may waive Medical Clearance.

CLINIC PROFESSIONAL VISIT FEE (if applicable)
☐ Our club will pay clinic fee $_____

HEARING EVALUATION
☐ Our club will pay the cost of an audiogram $_____

☐ Audiogram is enclosed (If client has test, subtract $ amount from total) current audiogram must be dated w/in last 6 months.

EARMOLD IMPRESSION (circle either 1 or 2)
☐ Our club will pay for cost of: **1 – 2** ear mold impression(s) **$**_____

FITTING AND SELECTION (circle either 1 or 2)
☐ Our club will pay the cost of the fitting and selection for **1 – 2** hearing aids **$**_____

HEARING AID DISTRIBUTION
☐ Our club will pay for **1** reconditioned hearing aid as recommended by the clinic. **$250.00**
☐ Our club will pay for **2** reconditioned hearing aids as recommended by the clinic. **$500.00**
☐ Our club will pay for a programmable hearing aid if recommended by audiologist (extra $50.00)

Check for full amount must accompany request or paperwork will not be processed.

Amount due for this Referral**$**_____

CLINIC TO BE USED

Club Name: _____ District_____

Club Representative:_____ E-mail:_____

Address:_____ City:_____ Zip_____

Home #:_____ Cell # _____ Work #_____