LIONS OF ILLINOIS FOUNDATION - SOCIAL SERVICE DEPARTMENT
RECONDITIONED HEARING AID APPROVAL FORM

700 N. Peace Road, Suite B
DeKalb, IL 60115
Phone: 815-756-5633 Fax: 815-748-9087

Clients Name: _____ Date: _____

Date of Birth: _____ Age: _____

Address: _____

City: _____ Zip: _____

Phone: _____ Email: _____

MEDICAL CLEARANCE: Client's health care provider will perform an exam to confirm the ear is clear of blockages. Physician may need to clear blockages and or wax build up from the ear canal.

☐ **Client will provide Medical Clearance** ☐ **Client may waive Medical Clearance**

***LIF will contact your Club if additional fee for Medical Clearance is requested.*

HEARING EVALUATION: ☐ **Club will pay for an Audiogram** ☐ **Audiogram is enclosed**

***Current Audiogram must be dated within the last 6 months (Please note: additional exam may be necessary to provide a fuller picture to help audiologists fit hearing aids more accurately.)*

HEARING AID(S) DISTRIBUTION: *As recommended by the Clinic*

☐ **Club will pay for the cost of (1) Reconditioned Hearing Aid *($250.00)***

Additionally:

☐ *Club will pay for cost of (1) Ear Mold Impression*
***Additional costs may apply (LIF will contact Club)*

☐ *Club will pay for cost of Fitting & Selection for (1) Hearing Aid*

TOTAL Due: $_____

☐ **Club will pay for the cost of (2) Reconditioned Hearing Aids *($500.00)***

Additionally:

☐ *Club will pay for cost of (2) Ear Mold Impressions*
***Additional costs may apply (LIF will contact Club)*

☐ *Club will pay for cost of Fitting & Selection for (2) Hearing Aids*

TOTAL Due: $_____

CLINIC TO BE USED: _____

*****Check for FULL AMOUNT MUST ACCOMPANY request or paperwork will not be processed.***

(Please make checks payable to: Lions of Illinois Foundation) AMOUNT DUE: $_____

Club Representative / Club: _____ District: _____

Phone: _____ Email: _____

Address: _____ City: _____ Zip: _____

Medical Clearance

Name:_____

Age:_____ **Birth Date:**_____

Address:_____

City:_____

State:_____ **Zip:**_____

TO BE COMPLETED BY A PHYSICIAN

The above named patient's hearing loss has been medically evaluated. He/She ears are free and clear of wax, infection and obstruction. He/She is considered to be a candidate for hearing aids. Medical clearance is granted for the purpose of wearing hearings aids:

_____**Yes** _____**No**

If medical clearance is not granted, please specify reasons for denial.

Date:_____ **X**_____
Physician

Clinic or Hospital Name and Phone Number

_____

_____

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