



Quota International of Wooster

APPLICATION FOR HEARING ASSISTANCE

Name of Applicant _____ Birthdate _____

Parent's name(s), if under age 18 _____

Address _____

Phone _____

Applicant or Parent's place(s) of employment _____

How long with employer? _____

List persons in your home: Name	Relationship to Applicant	Age
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_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Please indicate your needs (circle your indication):

Hearing Aid

Hearing Exam

Both Hearing Aid and Exam

Approximate costs _____

How much can you pay towards the costs? _____

Name of your provider _____

Location of your provider _____

Phone number of your provider _____

Please explain your hearing loss. Was it sudden or gradual? How long have you had your hearing loss? What caused your hearing loss? How has your hearing loss impacted your life?

Why do you need financial assistance? _____

Does anyone own real estate: _____ Value \$ _____

Do you own stocks, bonds, savings accounts, or other personal property of value? _____
List them _____

Gross monthly income \$ _____

<u>Do you receive any of the following:</u>	<u>Circle</u>		<u>Amount</u>
Unemployment compensation	Yes	No	\$ _____
Sick or accident benefits	Yes	No	\$ _____
Worker's comp/insurance benefits	Yes	No	\$ _____
OWF (Cash) welfare benefits	Yes	No	\$ _____
Medicaid (Medical Assistance)	Yes	No	\$ _____
Support payments	Yes	No	\$ _____
Veteran's benefits	Yes	No	\$ _____
Social Security/SSD/SSI	Yes	No	\$ _____
Pension	Yes	No	\$ _____
Social Service Agency	Yes	No	\$ _____
Hillburton Funds	Yes	No	\$ _____
Ohio Bureau of Crippled Children	Yes	No	\$ _____
Service Club Assistance	Yes	No	\$ _____
Other Assistance	Yes	No	\$ _____

Other Income (items not indicated above) \$ _____

Total Monthly Income \$ _____

Living Expenses:

Rent, mortgage payment, real estate tax \$ _____

Utilities: gas, electric, water, basic phone, cable
\$ _____

Medical (Medical bills and/or hospitalization premiums you pay) \$ _____

Daycare (if required) \$ _____

Net Monthly Income

\$ _____

How did you find out about Quota Club? _____

Have you applied to Quota Club before? _____ When? _____

Other circumstances that the committee should know when reviewing your application:

I HEREBY RELEASE ALL INFORMATION TO QUOTA INTERNATIONAL CLUB OF WOOSTER AND AUTHORIZE THAT IT IS TRUE TO THE BEST OF MY KNOWLEDGE. I GIVE PERMISSION FOR THE COMMITTEE TO INVESTIGATE THE ABOVE INFORMATION AS WELL AS THE RECOMMENDATION FROM THE HEARING AID PROVIDER TO DISCUSS COURSE OF ACTION.

SIGNED _____ DATE _____

Attached is an Informational Form as well as the three hearing aid providers who work with Quota. If obtaining from our website, please print the form as well as the medical clearance form. The medical clearance form needs to be signed by your health care provider and given to the hearing aid provider. Vista Hearing Aid Instruments and Audiology and Clearstone Hearing Aid Services, and Beltone Audiology & Hearing are the three providers who work with us. Please contact either one for an audiogram and hearing aid evaluation. A Hearing Loss Booklet will be sent to you as well to learn more about your hearing loss. The last page of this form will be sent to us from the provider attached to the test report. A decision will be mailed to your address. PLEASE RETURN THIS THREE-PAGE APPLICATION TO:

QUOTA INTERNATIONAL CLUB OF WOOSTER
P.O. BOX 1384
WOOSTER OH 44691

FOR COMMITTEE USE ONLY

Committee Discussion/Approval/Disapproval Date _____

Action _____

Board Approval Date _____ Membership Approval Date _____

Notification Mailed/Emailed _____ Booklet Mailed/Emailed _____

Provider Thirty-Day Hearing Aid Trial Report/Invoice _____

Follow-up Call to Applicant (hearing aid/booklet/etc) _____

Ask Applicant if willing to share their story with Quota/media _____

Committee Chair Signature _____



**THIS FORM MUST BE COMPLETED BY THE PROVIDER WHERE YOU WILL
OBTAIN YOUR NEEDS:**

Applicant's Name _____

Name of provider _____

Address _____

Explain, in layman's terms, the needs for this applicant:

Do you recommend the possibility of a hearing aid for the applicant? _____ if so, describe the hearing loss (e.g., mild, severe, upward or downward slope on audiogram, etc.)

Which brand(s) hearing aid will most likely be recommended for the applicant?
