Dear Applicant,

Thank you for your interest in the WWU Hearing Aid Bank Program. The goal of our program is to increase access to hearing health care in our local community. The Western Washington University Hearing Aid Bank Program operates on a donation-based system. This means hearing aids and funds for supplies are donated by community members. Individuals who we can help will depend on the availability of appropriate hearing aids in our inventory. Due to these restrictions, there may be associated wait times for those who qualify for the program.

Should you qualify, services will be provided by graduate students under the supervision of qualified Audiology professionals. You will be required to attend a series of four specific appointments at the WWU Hearing Clinic to receive all necessary services.

Please complete the attached application as accurately as possible. In addition to the completed application, you will be required to provide the following: most recent hearing test results (audiogram) if available, referral from physician (ENT, primary care provider) or audiologist, medical clearance for hearing aid use, and proof of income. Mail or fax the completed form and other required materials to:

Western Washington University
Audiology Clinic/Hearing Aid Bank
516 High Street, AI 394 MS 9171
Bellingham, WA 98225
Fax: (360) 650-4334

Your completed form and required materials will be reviewed by a panel consisting of the Audiology Clinic Director, Audiology Clinical Supervisor or Audiology Faculty members, and graduate students in the Clinical Doctorate of Audiology (Au.D.) Program. If you qualify, you will be contacted and the process will begin as soon as is possible!

Rieko M. Darling, Ph.D., CCC-A, FAAA
Professor
Director, Audiology Clinic and Au.D. Program

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https://chss.wwu.edu/csd/clinics

Revised 10-18-2021 R. Darling Ph.D.
HEARING AID BANK PROGRAM – APPLICATION

APPLICANT
Name: __________________________________________ Age: _____ Date of Birth: _______
Address: ____________________________________________________________________________ Apt: __________
City: __________________________________________ State: _______ Zip: __________
Phone Home: ___________ Cell: __________ Work: ________________
Marital Status: Single  Partnered  Married  Widowed  Divorced  Other  Pronoun: ______

SUPPORT PERSON/CARE GIVER:
Name: __________________________________________________________
Age: _____ Date of Birth: _______ Are you in the same household?  Yes  No
Phone: Home: ___________ Cell: _______________ Work: ________________

FINANCIAL INFORMATION:
1. Total number of people in household: (including you) _____
2. Household monthly income (including salary/wages, retirement, social security, SSI, DSHS, etc.) $______________________________
3. Household monthly expenses: (including rent/mortgage, utilities, phone, insurance, etc.)
   $ __________________________________
4. Total Personal monthly income:  $ __________________________________
5. Total Personal monthly expenses: $ __________________________________
6. Are you able to provide PROOF OF INCOME?
    Yes: _____ (Proof of income is attached)
    No: _____ please give explanation why proof of income cannot be given:
____________________________________________________________________________
____________________________________________________________________________
____________________________________________________________________________
____________________________________________________________________________

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7. Other financial restrictions/considerations/obligations (please list each item and associated dollar estimate):

_____________________________________________________________________________
_____________________________________________________________________________

8. How did you learn about the WWU Hearing Aid Bank Program?

_____________________________________________________________________________

_____________________________________________________________________________

**HEARING HEALTH:**

9. Have you had a previous hearing test (audiogram)?

<table>
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<tr>
<th>Yes</th>
<th>No</th>
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Where? _________________________________________________________________

When/how long ago? ______________________________________________________

What were the results/recommendations? ____________________________________

_____________________________________________________________________________

10. Do you have or suspect you have a hearing loss?

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<tr>
<th>Yes</th>
<th>No</th>
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If yes, in which ear/s? Right Left Both

When did your hearing loss begin? _________________________________________

Did your hearing loss occur gradually or suddenly? __________________________

Have you noticed a recent change in your hearing? ____________________________

Comments: ______________________________________________________________

_____________________________________________________________________________

11. Have you ever worn or tried hearing aids?

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<th>Yes</th>
<th>No</th>
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If yes, which ear? Right Left Both

When? ____________________ From where? _________________________________

How long have you worn hearing aids? ______________________________________

What are some of the benefits and limitations of your hearing aids? __________

_____________________________________________________________________________

12. What situations/environments do you find difficulty listening or understanding?

- Using the telephone
- Listening to women’s/children’s voices?
- Quiet Conversations
- In the presence of background noise
- In groups of people
- Other: _______________________________
- Watching the television
13. What are your greatest hearing concerns related to work/daily activities/etc.?
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________

14. Do you have any family members with hearing loss before the age of 50 years?
   If yes, what is their relationship to you? ____________    Yes    No

15. Do you hear ringing, buzzing, or other head noises (tinnitus)?    Yes    No
   If yes, which ear?    Right    Left    Both
   Is the sound constant or intermittent? _________________________________
   Can you describe the sound? _________________________________
   Rate the severity of your tinnitus on a scale of 1-5; 1 being minimal, 5 being unbearable:
   1  2  3  4  5

16. Do you have a history of ear pain, drainage, or ear infections?    Yes    No
   If yes, which ear?    Right    Left    Both
   When? _________________________________
   What were the symptoms? _________________________________
   What treatment was used/surgery? _________________________________

17. Do you have history of ear surgery?    Yes    No
   If yes, which ear?    Right    Left    Both
   Date/s of surgery? _________________________________
   What type/s of surgery? _________________________________

18. Do you currently, or have you ever experienced any dizziness?    Yes    No
   If yes, how would you describe your dizziness? _________________________________
   When did it start? ____________ What brings it on? _________________________________
   How often does it occur? _________________________________
   Have you seen a medical physician to treat your dizziness?    Yes    No
   Comments: _________________________________
19. Do you have a history of head trauma (concussion/skull fracture/etc.)? Yes No
If yes, please describe circumstances and dates of injury/ies: ______________________
________________________________________________________________________
________________________________________________________________________

20. Do you have any other health concerns (diabetes/kidney/heart/thyroid/etc.)? Yes No
If yes, please describe ____________________________________________________________________________
________________________________________________________________________

21. Do you currently take medications? Yes No
If yes, please list the name, dosage, description, and route below:
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________

Have you ever taken medications that might affect your hearing? Yes No
If yes, please describe: ____________________________________________________________________________

22. Do you have a history of noise exposure (military/work/recreation)? Yes No
If yes, please describe type of noise, duration of exposure, use of hearing protection:
________________________________________________________________________
________________________________________________________________________

OTHER PERTINENT INFORMATION:
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________

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ADDITIONAL REQUIREMENTS FOR QUALIFICATION:

23. I am able and agree to attend all individual appointment sessions required of the WWU Hearing Aid Bank Program. These sessions include:
   a. Comprehensive Hearing Evaluation Appointment
   b. Hearing Aid Evaluation and Consultation appointment
   c. Hearing Aid Fitting, Orientation, and Training Appointment
   d. Hearing Aid Follow-Up Appointment

24. I understand and agree that the WWU Hearing Aid Bank Program will not replace lost or pay for repair of damaged hearing aid/s and/or associated technologies

25. I agree to return any hearing aid/s or associated technologies to the WWU Hearing Aid Bank Program should I no longer need or desire to use such items

CHECKLIST TO BE COMPLETED BEFORE SUBMITTING APPLICATION

MATERIALS:

- Previous hearing test results (audiogram) included if available
- Referral from physician (ENT, primary care provider) or audiologist
- Medical Clearance for hearing aid use
- Proof of Income included
- Completed application form (to the best of your ability)

Applicant Signature: ________________________________ Date: ____________