



Communication Sciences and Disorders

Hearing Aid Bank Program

Speech-Language-Hearing Clinic

Academic Instructional Center, 256 – MS 9171
516 High Street, Bellingham, Washington 98225-9171

Phone (360) 650-3881 - Fax (360) 650-4334
<https://chss.wvu.edu/csd/clinics>

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!

A handwritten signature in blue ink that reads "Ashley Sobchuk-Hudson".

Ashley Sobchuk-Hudson, Au.D., CCC-A
Audiology Clinic Director

Person completing form: _____ *If not client, relation to client:* _____

Signature: _____ *Date:* _____

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:

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)? Yes No

Where? _____

When/how long ago? _____

What were the results/recommendations? _____

10. Do you have or suspect you have a hearing loss? Yes No

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? Yes No

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:

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:** _____