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!

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

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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)?
   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

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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: ___________