Dear Applicant

The goal of the WWU Hearing Aid Bank Program is to help as many individuals in our local community as is possible to acquire hearing help. However, because the Western Washington University Hearing Aid Bank Program operates on a donation based system, the number of individuals assisted with hearing aids will depend on the availability of appropriate hearing aids in the bank inventory as well as funds available to cover any associated costs. Even if you qualify there may be a period of waiting due to these factors.

As an academic institution we must also balance the needs of each potential client with our goal to provide the best educational and training experiences for our graduate Audiology students. This means that you will be provided excellent services by graduate students under direct supervision of qualified Audiology professionals. This also means that provision of such services will require multiple appointment visits to the WWU Audiology (Hearing) Clinic.

Please complete the pages that follow as accurately as possible. It will also be beneficial if any previous hearing test findings or a supportive note from a referring audiologist, hearing aid dispenser, or civic service organization (i.e. Hearing Loss Association of America, Lions Club, Kiwanis, etc.) is returned with your completed form and other required materials. 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 other materials will be reviewed by a panel consisting of the Audiology Clinic Director, an Audiology Clinical Supervisor or Audiology Faculty member, and a graduate student in the Clinical Doctorate in 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
Professor
Director, Audiology Clinic and Au.D. Program
Person completing form: ______________________ If not client, relation to client: ____________

Signature Date

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HEARING AID BANK PROGRAM – APPLICATION (please print)

APPLICANT

Name: ____________________________________ Age: ___ Date of Birth: ________
Last First MI
Address: ____________________________ Apt#: __________________
City __________________________ State: ___ Zip __________________
Phone: Home __________ Cell __________ Work __________________

Marital Status: Single ____ Married ___ Widowed ___ Divorced ____ Other _____

SPOUSE

Name: ____________________________________ Age: ___ Date of Birth: ________
Last First MI
Are you in the same household? Yes _____ No ______
Phone: Home __________ Cell __________ Work __________________

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

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

7. Able to provide PROOF OF INCOME?

Yes _____ Proof is attached _____

No _____ Why proof is not available __________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

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

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

OTHER INFORMATION:

9. Previous hearing evaluations: Yes No

Where: __________________________________________

When: __________________________________________

What were the results? __________________________________________

What were the recommendations? __________________________________________

10. Hearing loss:

If YES, which ear? Right Left Both

Is one ear better than the other? If YES, which? Right Left

When did the hearing loss begin/age of onset? ______________________

Did the loss occur SUDDENLY or GRADUALLY? ______________________

Has it gotten worse? Yes No

Comments: __________________________________________
11. Do you have difficulty in specific listening situations?  
   Yes      No  
   If YES, check all that apply:  
   [ ] Using the telephone  [ ] Women and children’s voices  
   [ ] Quiet conversation (one-to-one)  [ ] In the presence of background noise  
   [ ] In groups of people  [ ] Other: ________________________  
   [ ] Watching television

12. Do you have any family members that had hearing loss before age 50?  
   Yes      No  
   If YES, what is their relationship to you? ____________________________________________

13. Do you hear ringing, buzzing, or other head noises?  
   Yes      No  
   If YES, which ear?  Right  Left  Both  
   Is it CONSTANT or INTERMITTENT? _____________________________________________  
   Rate the severity on a scale of 1 to 5, 1 being minimal and 5 being unbearable:

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14. Do you have a history of ear pain, drainage or ear infections?  
   Yes      No  
   If YES, which ear?  Right  Left  Both  
   When did this occur? _____________________________________________  
   What were the symptoms? _____________________________________________  
   How was it treated? _____________________________________________

15. Do you have a history of ear surgery?  
   Yes      No  
   If YES, which ear?  Right  Left  Both  
   Date(s) of surgery? _____________________________________________  
   What type(s) of surgery? _____________________________________________  

16. Do you have a history of dizziness?  
   Yes      No  
   If YES, how would you describe your dizziness? _____________________________  
   When did it start? _____________________________________________  
   What brings it on? _____________________________________________  
   How often does it occur? _____________________________________________  
   Has medical consultation been obtained?  Yes      No  
   Comments: _____________________________________________

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17. Do you have a history of head trauma? 
   Yes  No
   *(EX. Skull fracture, concussion, unconsciousness)*
   If YES, please describe, including dates and circumstances ______________________________
   _____________________________________________________________

18. Do you have a history of other health problems? 
   Yes  No
   *(EX. diabetes, kidney, circulatory/heart, thyroid, infections, etc.)*
   If YES, please describe: _____________________________________________
   _______________________________________________________________

19. Do you currently take medications? 
   Yes  No
   If YES, what medication(s)? _________________________________________
   What reason(s)? __________________________________________________
   To your knowledge, have you ever taken a medication that
   might affect your hearing? Yes  No
   Please describe: _______________________________________
   __________________________________________________________

20. Do you have a history of noise exposure? 
   Yes  No
   *(EX. Armed services, work, recreation)*
   If YES, please describe where it occurred: _____________________________
   How many years exposed? _________________________________________
   How many hours exposed per day? _________________________________
   Was hearing protection worn? ______________________________________
   When was your last exposure to noise? ______________________________

21. Have you ever worn or tried hearing aids? 
   Yes  No
   If YES, what style? *(BTE, RITE, ITE, ITC, CIC)*
   Ear Fitted: Right  Left  Both
   When obtained: ___________________________________________________
   Where obtained: __________________________________________________
   Period Worn: ____________________________________________________
   Benefit/limitations? ______________________________________________
   Comments: _______________________________________________________

22. What are your greatest hearing concerns related to work, daily activities, etc.? __________
   ___________________________________________________________________
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 appointment sessions include:

   a. Comprehensive Hearing Evaluation appointment
   b. Hearing Aid Fitting and Evaluation appointment
   c. Hearing Aid Orientation, Training, and Counseling appointment
   d. Hearing Aid Follow Up appointment (1 month)

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 associated products or equipment.

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

I present my signature below to indicate that I understand the qualification requirements for WWU Hearing Aid Bank Program.

Applicant Signature:__________________________ Date: __________________________