APPLICATION FOR HEARING AIDS

Application Instructions:

- If you need help finding a clinical audiologist or paying for clinical audiology services, please contact Hear in the Fox Cities directly.
- Having insurance is not exclusionary; Hear in the Fox Cities understands that high deductibles and copays may still make the purchase of hearing aids difficult without assistance.
- Hearing aid repairs and earmolds costs may be covered, separate from new hearing aid orders.
- Clinical Audiologist completes clinical audiology portion of the application.
- Parent/guardian completes parent portion of the application.
- Applications can be mailed to Hear in the Fox Cities, 1948 Palisades Dr, Appleton WI 54915 faxed, 920-882-3715 or scanned and emailed to hear@hearinthefoxcities.org
- Applications will be reviewed by the board in a timely manner and the applicant will be contacted with a decision.

Parent Portion - pages 2 -4
Clinical Audiologist portion 3-7

Hear
In the Fox Cities

TO BE COMPLETED BY THE PARENT

Patient: _____ Male/Female DOB: ___/___/_____

Insured Person:_____ Insured DOB:___/___/_____

Relationship to patient: _____ Phone #: _____

Does patient have Insurance?_____YES _____ NO

Were you denied coverage? _____ YES _____NO

Insurance Information – primary (found on insurance card):

Insurance Company Name: _____

ID #:_____Group #: _____

Employer (of Insured):_____

Insurance Information – secondary *(if applicable)*

Insurance Company Name _____

ID # :_____Group #:_____

Employer (of Insured): _____

By signing below, I am giving permission to release records relating to Audiology and other records related to my hearing and to contact my health insurance about eligibility notices and information on coverage for hearing aids for my child.

_____/_____/_____ X_____

Date *Patient/Parent/Legal Guardian*

If yes is there a financial hardship? __Yes __No

If yes, please explain, please provide income and expense statements: (ie medical bills, loss of income, other extenuating circumstances) add additional pages and documentation if needed.

HEAR in the Fox Cities will provide funding for hearing aids as long as the funds are available. We reserve the right to change eligibility at any time without written notification.

Consent form for the use of photographs or video

HEAR in the Fox Cities recognizes the need to ensure the welfare and safety of all young people receiving hearing aid donations.

We would be grateful if you would give us permission to take photos or videos of your child and use these in our printed and online publicity.

I give permission to take photographs and / or video of my child. I grant full rights to use the images resulting from the photography/video filming, and any reproductions or adaptations of the images for fundraising, publicity or other purposes to help achieve the group's aims.

This might include (but is not limited to), the right to use them in our printed and online publicity, social media, and press releases.

Name of child _____

Name of parent / guardian _____

Signature of parent / guardian _____

Date _____

TO BE COMPLETED BY CLINICAL AUDIOLOGIST

Audiologist Information

Name of Audiologist: _____ Date: _____

Name of Practice: _____

Address: _____

City: _____State: _____Zip Code: _____

Phone #:_____ Fax #: _____Email :_____

Patient Information

Child's Name:_____DOB: _____

Please explain why you are recommending this child for Hear in the Fox Cities funding. Attach extra sheets if necessary.

_____

_____

_____

Audiologic Information

Attach a copy of Audiogram taken within 6 months.

Type of hearing loss

Right:	___Conductive	___Sensorineural	___Mixed	___Auditory Neuropathy
Left:	___Conductive	___Sensorineural	___Mixed	___Auditory Neuropathy

Most recent hearing aid fitting date _____

Currently wearing: ___BTE ____Open Fit ___RIC ____CIC ____ITE ____ None

Current fit is: _____Binaural _____Right Ear only _____Left ear only ___CROS

In which ear is hearing aid being requested for? _____Right _____Left _____Both

Anything else we should know?

_____

_____

_____

HEARING AID PREFERENCES: What are you recommending?

_____

_____

PLEASE SEND THE FOLLOWING DOCUMENTS

Please send copies (not originals)

_____ Audiogram and appropriate records

By printing your name below, you affirm that the information contained in this application is current and complete. If any change in information occurs, please notify us immediately.

Upon acceptance as the hearing aid provider for your patient, you agree to the following terms:

a) To recommend and fit the optimum amplification that is most appropriate for thechild seeking funding. Y or N

b) To schedule the appointment as soon as possible to expedite the fitting of hearing aid(s)

c) Patient will be fit using best practices and fitting will be verified with Real Ear measurements.

d) Parents will be explained the benefits of hearing loops and telecoils and provided with an educational handout. (Provided by HEAR in the Fox Cities).

e) To return the hearing aid(s) purchased by HEAR in the Fox Cities if a patient no longer needs the hearing aids or the fitting does not happen.

f) Complies with all provisions of federal and state laws and regulations relating to the dispensing of hearing aids.

g) Audiologist will provide an itemized (unbundled) bill to Hear in the Fox Cities for Review. Hear in the Fox Cities fitting dispensing fee is 500 dollars per ear, for one year of service. Example, hearing aid invoice cost including shipping, earmold/s, plus 500 dollars for each ear (total 1000.00)

h) Although it is expected that the full manufacture warranty, including loss and damage warranties, will be passed on to the patient. Office visits/service charges after one year are billable to the patient.

i) If loss and damage deductibles, office visits, or out of warranty repairs are prohibitively expensive patients/audiologists are encouraged to reapply.

Signature of Provider_____Date _____

Printed Name: _____

Sliding Scale Explanation:

Hear in the Fox Cities uses the sliding scale above which outlines general financial considerations. The scale is used as a guideline in determining if families may be required to “share in the cost” of hearing aids for their child. Applications for hearing aid funding assistance will be reviewed by Hear in The Fox Cities and a determination will be made as to whether or not parents have an ability to pay a “share” of the cost of hearing aids. Based on this review, families may be required to contribute a portion of funds toward the cost of their child’s hearing aid/aids. The sliding scale/cost share system is based on a family’s gross income and family size.

Exceptions to the sliding scale cost share guideline, however, will be considered. If extenuating circumstances demonstrate significant financial difficulties exceptions may be made. Examples of these may include significant medical bills, job loss, etc..Families are strongly encouraged to apply for an exception when circumstances would preclude a family from moving forward with hearing aids for their child.