

HearU Nebraska/Nebraska Children's Hearing Aid Bank
APPLICATION FORM

The intent of both the Nebraska Children's Hearing Aid Bank & HearU Nebraska is to provide hearing aids and/or audiological services for children who otherwise would not be able to afford these services. We ask that you only apply for this program if the needed hearing aids and/or audiological services are not fully covered by another source and would produce an undue financial hardship for your family. Your consideration will ensure that the greatest number of children will be served through these programs.

Please complete parts A-D of this application and mail or fax to:

HearU Nebraska/Nebraska Children's Hearing Aid Bank
University of Nebraska-Lincoln
Barkley Memorial Speech, Hearing & Balance Clinic
Room 204
Lincoln, NE 68583-0731
Phone: (402) 472-0043 **Fax: (402) 472-3814**

Program Director: Stacie Ray, Doctor of Audiology **(402) 472-2075**

The information contained on this form will be kept confidential.

PART A – To be completed by the referring audiologist

Referring Audiologist Information

Audiologist's Name: _____

Practice Name: _____

NE Audiology License #: _____

Mailing Address: _____

Phone Number: _____ Fax Number: _____

Child's Information

Name: _____ Date of Birth: _____

Parent/Legal Guardian's Name: _____

Mailing Address: _____ Residential Address: _____

Phone Number: _____ Alternate Phone: _____

E-mail Address _____
Alternate Contact: _____

PART B

To be completed by the referring audiologist

In order for this request to be processed, please confirm that the following have been completed:

- _____ Audiometric testing (please send copy of test results)
- _____ Medical clearance
- _____ Signed parent agreement form

Was this child referred to you based upon the failure of the Universal Newborn Hearing Screening protocol? Yes _____ No _____

If yes, from which hospital? _____

What is the configuration (if known) and degree of hearing loss?

Is this a binaural or monaural fitting? _____

Please indicate using the list below the make, model and color of hearing aid that you would recommend for this child, numbering preferences 1-3. While we cannot guarantee the exact make and model, please be assured that every attempt will be made to match your request.

- 1. _____
- 2. _____
- 3. _____

The hearing aid(s) will be sent to the requesting audiologist within 7 days of receiving the application and required documentation. The hearing aid will be selected and sent by the Hearing Aid Loaner Bank based on the information received.

Audiologist Signature

Date

PART C

To be completed by the parent or legal guardian

1. Please provide a brief statement indicating the reason assistance from the loaner bank is requested. (Please describe why you cannot provide immediate access to hearing aids for your child)

2. Do you currently have insurance coverage to secure permanent hearing aids for your child? If yes, have you contacted your insurance company to apply for hearing aids? Please indicate the insurance company name, and the status of your contact.

3. Are you currently eligible for Medicaid or Kid's Connection? If yes, have you contacted Medicaid/Kid's Connection to approve payment for the hearing aids?

4. Do you need information regarding resources to secure permanent hearing aids?

Signature of Parent/Legal Guardian _____ Date _____

PART D

HEARING AID AGREEMENT

_____ I agree that my child will receive (a) loaned hearing aid(s) from HearU Nebraska/Nebraska Children's Hearing Aid Bank

_____ I agree to provide a brief statement indicating the reason assistance is requested.

_____ I agree that it is my responsibility to maintain and care for the hearing aid(s) and that I will be responsible for any loss or damage not covered by the hearing aid warranty up to \$100.00. This excludes normal wear and tear.

_____ I agree that my child will have use of this/these hearing aids(s) for the extent of the three-year loan period. I will complete a renewal or extension application if my child needs to use these hearing aids beyond the three-year loan period.

_____ I agree that if for any reason my child no longer uses the hearing aids, or qualifies for benefits that provide hearing aids through insurance, I will return the loaned hearing aid(s) to my child's audiologist, to be returned to the loaner bank.

_____ I agree to release my child's hearing loss information to the Nebraska Children's Hearing Aid Loaner Bank, Nebraska's Early Hearing Detection and Intervention Program, Early Development Network and my local Regional Program.

Please provide the following demographic information for your child (check all that applies):

_____ Male
_____ Female

Origin:

Spanish/Hispanic/Latina(o)

_____ Mexican
_____ Puerto Rican
_____ Cuban
_____ Other (specify) _____

Race:

_____ White	_____ Japanese
_____ Black or African American	_____ Korean
_____ American Indian/Alaska Native (specify)	_____ Vietnamese
_____ Asian Indian	_____ Other Asian (specify)
_____ Chinese	_____ Native Hawaiiin
_____ Filipino	_____ Guananian or Chamorro
_____ Other Pacific Island (specify)	_____ Samoan
_____ Other (specify) _____	

Parent/Legal Guardian Signature

Date