



# HearU Application Audiologist's Section

Audiologists: please complete parts A & B and send with audiogram. Have parent/legal guardian complete parts C & D and mail or fax to the information at the bottom of the page.

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:	
NE Audiology License #:	
Practice Name:	
Phone Number:	
Email Address:	
Mailing Address:	
Child's Information	
Name:	
Date of Birth:	



Address:

Nebraska Hearing Aid Banks 156 Barkley Memorial Center Lincoln, NE 68583



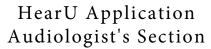
hearingaidbanks@unl.edu



Phone: (402)472-0043









#### PART B: To be completed by the referring audiologist

In order for this request to be processed, please confin	m that the following have been completed:
Audiometric testing within the last 6 mon	ths (please send copy of test results)
Medical clearance	
Signed parent agreement form (Part C of	this document)
Universal Newborn Hearing Screening results?	Pass Refer Unknown
Is this a binaural or monaural fitting? Monaural	_ (Circle: Left/Right) Binaural
Please indicate using the list below the make, model, j	power level and color of hearing aid that you would
recommend for this child. While we cannot guarantee	the exact make and model, please be assured that every
attempt will be made to match your request.	
Choice 1:	Choice 2:
Manufacturer:	Manufacturer:
Model & Power Level:	Model & Power Level:
Color:	Color:
If RIC, length and strength of receiver:	If RIC, length and strength of receiver:
Comments:	
Every attempt will be made to send the hearing aid(s)	to the requesting audiologist within 7 days of receiving the
application and required documentation. However, t	his process may be delayed while insurance is verified. The
hearing aid will be selected and sent by HearU Nebras	ka based on the information received.
Audiologist Signature:	Date:
5 5	



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### HearU Application Parent/Legal Guardian Section

The intent of HearU Nebraska is to provide hearing aids and/or audiological services (including dispensing fees and earmolds, but excluding diagnostic testing) 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.

The information contained on this form will be kept confidential.

#### PART C: To be completed by parent/legal guardian

Parent/Legal Guardian Name(s):			
Audiologist's name and clinic:			
Child's Name:		Date of Birth:	
Street Address:			
Cit y:		Zip Code:	
Phone Number:		Alternate Phone:	
Email Address:			
1.Please provide a brief statemen	t indicating the rea	son why you are applying for assistance fro	m HearU
Nebraska.			



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Nebraska Hearing Aid Banks 156 Barkley Memorial Center Lincoln, NE 68583



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# HearU Application Parent/Legal Guardian Section



2. Name of Insurance Company:	Member ID:
Name of primary member:	
Does your insurance company offer any hearing aid benefits?	
Yes: No: Unknown:	
If yes, please describe the benefits that are offered:	
3. Are you currently eligible for:	
Medicaid? Yes: No: Unknown:	
Medically Handicapped Children's Program? Yes:	No: Unknown:
Children's Health Insurance Program (CHIP)? Yes:	No: Unknown:
If you have not contacted one of the three programs above an	d are unsure of you eligibility,
please visit the website below for online applications and con	ntact information:
Medicaid: http://dhhs.ne.gov/medicaid/Pages/Medicaid-El	igibility.aspx
Medically Handicapped Children's Program: http://dhhs.n	e.gov/pageshcs_programs_mhcp.aspx
Children's Health Insurance Program (CHIP): http://dhhs	.ne.gov/medicaid/Pages/med_CHIP.aspx
4. Have you applied for any other financial assistance for obtaining leads what was the outcome?	hearing aids? If so, with whom and



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## HearU Application Parent/Legal Guardian Section

5. Income Info	rmation		
A. Hou	ısehold Mon	thly Income:	
	\$	Employment	
	\$	Social Security (SSI,	SSDI)
	\$	Welfare Benefits (A)	DS, Unemployment, Medicaid)
	\$	Alimony, Child Sup	port
	\$	Veteran's Benefits	
	\$	Other	
B. Tota	al Number of	f People in the Household:	
Ages (	everyone in l	household):	
C. Any	Other Hold	lings (over \$2000, not includin	ng 401K):
	Current am	nount in savings: \$	
	Certificate	e of Deposit: \$	
	Stocks/Bor	nds/Other: \$	
D. Ple	ase feel free	to list any other information	you feel would be helpful to understand you
financial situa	ation (such a	as monthly expenses, medical	expenses, etc.) and to make a better decision
about your eli	igibility.		
I certify that	the above in	formation is accurate:	
Signature of P		Guardian	 Dat e

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# HearU Application Parent/Legal Guardian Section



Part D	
	HEARING AID AGREEMENT
I agree that my child will receive (a) le	
I understand that Hear U Nebraska's lo for the hearing aid(s) while my child is usin	an period is five years and that it is my responsibility to maintain and care g the loaner device(s).
	repair warranty is five years. During this time, repairs will be covered at no e that I will be responsible for costs of repairs.
replacement per aid. If the device(s) is lost	loss and damage warranty is five years and comes with a one-time during the warranty period, I agree to pay \$150 per device. If the device is understand that I may be asked to reapply, and HearU will make a tement device(s).
I agree that my child will have use of t complete a renewal or extension application	this/these hearing aid(s) for the extent of the five-year loan period. I will if my child needs to use these hearing aids beyond the five-year loan period.
I agree that if for any reason my child aids through insurance, I will return the loa Nebraska.	no longer uses the hearing aids, or qualifies for benefits that provide hearing and hearing aid(s) to my child's audiologist, to be returned to HearU
I agree to release my child's hearing lo and Intervention Program, Early Developme	oss information to the HearU Nebraska, Nebraska's Early Hearing Detection ent Network and my local Regional Program.
Please provide the following demographic in	nformation 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	Vietnamese
Asian Indian	Other Asian (specify)
Chinese	Native Hawaiian
Filipino	Guananian or Chamorro
Other Pacific Island (specify)	Samoan
Other (specify):	



Address:

Parent/Legal Guardian Signature

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Date

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