



NEBRASKA HEARING AID BANKS

HearU Application

Audiologist's Section



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 within the last 6 months (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, 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:

Manufacturer: _____

Model & Power Level: _____

Color: _____

If RIC, length and strength of receiver: _____

Choice 2:

Manufacturer: _____

Model & Power Level: _____

Color: _____

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, this process may be delayed while insurance is verified. The hearing aid will be selected and sent by HearU Nebraska based on the information received.

Audiologist Signature: _____ Date: _____



Address:

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



Email:

hearingaidbanks@unl.edu



Phone: (402)472-0043



Fax: (402)472-0363



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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:

City: _____ State: _____ Zip Code: _____

Phone Number: _____ Alternate Phone: _____

Email Address: _____

1. Please provide a brief statement indicating the reason why you are applying for assistance from HearU Nebraska.



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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 and are unsure of your eligibility,
please visit the website below for online applications and contact information:

Medicaid: <http://dhhs.ne.gov/medicaid/Pages/Medicaid-Eligibility.aspx>

Medically Handicapped Children's Program: http://dhhs.ne.gov/pageshcs_programs_mhpc.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 hearing aids? If so, with whom and
what was the outcome?



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Parent/Legal Guardian Section



5. Income Information

A. Household Monthly Income:

\$_____ Employment

\$_____ Social Security (SSI, SSDI)

\$_____ Welfare Benefits (ADS, Unemployment, Medicaid)

\$_____ Alimony, Child Support

\$_____ Veteran's Benefits

\$_____ Other _____

B. Total Number of People in the Household: _____

Ages (everyone in household): _____

C. Any Other Holdings (over \$2000, not including 401K):

Current amount in savings: \$_____

Certificate of Deposit: \$_____

Stocks/Bonds/Other: \$_____

D. Please feel free to list any other information you feel would be helpful to understand your financial situation (such as monthly expenses, medical expenses, etc.) and to make a better decision about your eligibility.

I certify that the above information is accurate:

Signature of Parent/Legal Guardian

Date



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NEBRASKA HEARING AID BANKS

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Parent/Legal Guardian Section



Part D

HEARING AID AGREEMENT

- _____ I agree that my child will receive (a) loaned hearing aid(s) from HearU Nebraska.
- _____ I understand that HearU Nebraska's loan period is five years and that it is my responsibility to maintain and care for the hearing aid(s) while my child is using the loaner device(s).
- _____ I understand that a typical hearing aid repair warranty is five years. During this time, repairs will be covered at no cost. Beyond the repair warranty, I am aware that I will be responsible for costs of repairs.
- _____ I understand that a typical hearing aid loss and damage warranty is five years and comes with a one-time replacement per aid. If the device(s) is lost during the warranty period, I agree to pay \$150 per device. If the device is lost after the end of the warranty period, I understand that I may be asked to reapply, and HearU will make a determination regarding coverage for replacement device(s).
- _____ I agree that my child will have use of this/these hearing aid(s) for the extent of the five-year loan period. I will complete a renewal or extension application if my child needs to use these hearing aids beyond the five-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 HearU Nebraska.
- _____ I agree to release my child's hearing loss information to the HearU Nebraska, 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 | _____ Vietnamese |
| _____ Asian Indian | _____ Other Asian (specify) |
| _____ Chinese | _____ Native Hawaiian |
| _____ Filipino | _____ Guamanian or Chamorro |
| _____ Other Pacific Island (specify) | _____ Samoan |
| _____ Other (specify): _____ | |

Parent/Legal Guardian Signature

Date



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