Hear for Kids Application

Parent/Guardian Section

Thank you for applying for Hear for Kids, a charitable program providing services for financially eligible children in need of hearing evaluation, hearing aids, cochlear implant repairs or medical clearance for hearing aid fitting. Eligibility is based on income criteria and funds available. Hear for Kids is made possible through generous funding provided by the *Vitalyst Health Foundation*.

Child's Name: _____ Date of Birth: _____

Home Address: _____ ZIP Code: _____

Email: _____ Parent/Guardian Phone Number: _____

Person Responsible: _____ Relationship: ☐ Mother ☐ Father ☐ Guardian

Specify if the child is eligible or enrolled in any of the following:

AHCCCS ☐ Applied ☐ Enrolled ☐ Denied ☐ Waiting for Results ☐ N/A
KidsCare ☐ Applied ☐ Enrolled ☐ Denied ☐ Waiting for Results ☐ N/A

Is your child eligible for Indian Health Services? ☐ Yes ☐ No
Is your child insured under any health plan? ☐ Yes ☐ No

- If yes, who is coverage provided by _____

Please explain coverage limits for hearing aids, earmolds, fitting and/or repairs

_____

Income

Total household income for the past 12 months: $_____

- *Include: Wages/salary, Pension, Social Security, Child Support and any other income.*

Number of family members living in the household: _____

Parent/Guardian Responsibility

If your child is eligible, and funding is available, you will receive the services or devices requested. Proof of income may be requested at any time. Hear for Kids will not accept financial responsibility for any additional tests, treatment or office visits. By signing this form, you agree to release information to Desert Voices. Information specific to your child and his/her hearing loss may be shared with other medical, audiology and early intervention professionals or agencies through the mail, phone, email or fax. Information that doesn't specifically identify your child may be published, reviewed for utilization, quality assurance or used to pursue funding for the program.

Parent or Guardian Signature:_____ Date: _____

Email applications to *hearforkids@desert-voices.org* or fax to Desert Voices at 602-224-0598

Tel: (602) 224-0598
Fax: (602) 224-2460
3426 E Shea Blvd.
Phoenix AZ 85028

Hear for Kids Application

Audiologist/Referring Provider Section

Child's Name: _____ Date of Birth: _____

Audiologist/Referring Provider: _____ Facility: _____

Phone Number: _____ Email: _____

Eligibility is based on the family income being at or below 250% of the Federal Poverty Level for the number of family members in the household. If the family is eligible and there is funding available, a voucher will be emailed to the audiologist or referring provider via secure email. If the family does not qualify based on income but there are special circumstances, please contact Desert Voices.

A chart outlining the current eligible income levels is available on the Desert Voices Hear for Kids website. By signing below, you attest to trusting the family's household income is at or below 250% of the Federal Poverty Level as listed on the Desert Voices Hear for Kids website, and agree to the following:

- Follow best practices for determining eligibility, preforming diagnostic hearing evaluation, selecting and fitting hearing aids, and programming cochlear implants.
- Provide Hear For Kids with patient records and proof of income, if requested.
- Provide appropriate follow up as needed for **one year** after fitting at no additional charge.
- Agree to accept Hear for Kids voucher as playment in full and not bill family any additional amount.
- Inform the family of recommended specialty care for newly identified hearing losses.

Audiologist/Referring Provider Signature: _____ Date: _____

□ **Diagnostic Hearing Test Request**
Type of testing needed: □ Natural Sleep BAER □ Sedated BAER □ VRA/CPA □ Conventional

□ **Medical Clearance for Hearing Aid Fitting Request**

□ **New Hearing Aid Request**
Number of Hearing Aids Requested: □ 1 □ 2
HA Manufacturer: □ Oticon □ Phonak □ Resound □ Cochlear □ Oticon Medical
Device Model/Level: _____
Earmold Manufacturer: □ All American □ Emtech □ Microsonic □ Westone □ N/A
Fitting and follow up fee ($300): □ Yes □ No
*Fee only allowed if not covered by other agency

□ **Hearing Aid Repair Request**
Repair Request: □ Oticon □ Phonak □ Resound □ Cochlear □ Oticon Medical
Issue with device: _____

□ **Cochlear Implant Repair/Serviec Request**
Cochlear Implant Company: □ Cochlear Americas □ Advanced Bionics □ MED-EL
Part(s) Needed: _____
Programming fee ($250): □ Yes □ No

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desert voices
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