

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: _____ Phone: _____

Person Responsible: _____ Relationship: ☐ Parent ☐ Guardian

- Is your child eligible or enrolled in AHCCCS? ☐ Yes ☐ No
- Is your child eligible or enrolled in KidsCare? ☐ Yes ☐ No
- 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 a voucher to be used for the services. Authorization to purchase devices will be sent to the fitting audiologist. 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 602-224-2460

Hear for Kids Application

Audiologist/Referring Provider Section

Child's Name: _____ Date of Birth: _____

Audiologist/Referring Provider: _____ Facility: _____

Email: _____ Phone Number: _____

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, performing 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 payment in full and not bill family any additional amount.
- Inform the family of recommended specialty care for newly identified hearing losses.

Provider Signature: _____ Date: _____

Request

☐ Diagnostic Hearing Test

Type of testing: ☐ Natural Sleep BAER ☐ Sedated BAER ☐ VRA/CPA ☐ Conventional

☐ Hearing Aids

Number of Hearing Aids Requested: ☐ 1 ☐ 2

HA Manufacturer: ☐ Cochlear ☐ Oticon ☐ Oticon Medical ☐ Phonak ☐ Resound

Device Model/Level: _____

Earmold Manufacturer: ☐ All American ☐ Emtech ☐ Microsonic ☐ Westone

Fitting and Follow-Up Fee: ☐ Yes ☐ No

☐ Medical Clearance for Hearing Aid Fitting

☐ Cochlear Implant Repair/Service

Cochlear Implant Company: ☐ Advanced Bionics ☐ Cochlear ☐ MED-EL

Part(s) Needed: _____

Programming Fee: ☐ Yes ☐ No

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