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

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

desert voices
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