



**HEAR for Kids®** is a program for children who need hearing aids and earmolds and meet financial criteria. It is made possible by a grant from St. Luke's Health Initiatives and private donations.

**Parent/Guardian Please Complete this Section**

Child's Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Home Address: \_\_\_\_\_

Birth Hospital: \_\_\_\_\_ 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  Not Applicable

**KidsCare**  Applied  Enrolled  Denied  Waiting for Results  Not Applicable

Is your child eligible for **Indian Health Services**?  No  Yes

Is your child insured under any health plan?  No  Yes Coverage is provided by \_\_\_\_\_

Please explain coverage limits for hearing aids, earmolds and fitting \_\_\_\_\_

**Income**

Total Household income for the past 12 months: \$ \_\_\_\_\_

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

**Expenses**

Number of family members living in the household: \_\_\_\_\_

Total Allowed Deductions for the past 12 months: \$ \_\_\_\_\_

*Include: Total medical/dental not paid for by health insurance or third party, Annual rent or mortgage payment, Annual payments for primary vehicle, Dependent Care. For dependant care, use the following calculations:*

*Number of children in childcare \_\_\_\_\_ x \$200 x number of months \_\_\_\_\_ = \_\_\_\_\_*

*Number of incapacitated adults receiving care \_\_\_\_\_ x \$100 x number of months \_\_\_\_\_ = \_\_\_\_\_*

**Parent responsibility**

If your child is eligible, and funding is available, you will receive earmolds and hearing aids. The EAR Foundation of Arizona will *not* accept financial responsibility for any additional tests, treatment or office visits. By signing this form, you agree to release information to The EAR Foundation of Arizona. 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: \_\_\_\_\_ Date \_\_\_\_\_

**HEAR for Kids® – Permanent Hearing Aid Request**

**Audiologist Please Complete this Section**

Child's Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Date of Request: \_\_\_\_\_ Audiologist's Name: \_\_\_\_\_

Facility/Agency \_\_\_\_\_ Address \_\_\_\_\_

Phone Number: \_\_\_\_-\_\_\_\_-\_\_\_\_ Fax Number: \_\_\_\_-\_\_\_\_-\_\_\_\_ Email: \_\_\_\_\_

**Audiologist Responsibility:**

- Follow the current Arizona Pediatric Audiology guidelines for eligibility and fitting.
- Provide HEAR for Kids® with patient records and proof of expense and income, if requested.
- Provide appropriate follow up as needed for one year after fitting at no additional charge.
- Inform the family on recommended specialty care for newly identified hearing losses.

Determine eligibility by subtracting amount in the **Expenses** section from the amount in the **Income** section and reviewing the following chart (current as of 8/06).

Number in Family	Annual Income	Number in Family	Annual Income	Number in Family	Annual Income
1	\$15,315	3	\$25,755	5	\$36,195
2	\$20,535	4	\$30,975	6	\$41,415

For each additional person, add \$5,220

*If the family income is at or below the listed amount for the number of family members the child will be eligible. If money is available, a voucher will be faxed to you to be given to the family. If the family does not meet the qualifications but there are special circumstances, please call Lylis Olsen at (602) 690-3975.*

1. Review the list of Vendors currently on contract with HEAR for Kids®.

**HEARING AIDS:** AVR Sonavation, Oticon, Phonak, Siemens, Starkey, Unitron, Widex

**EARMOLDS:** All American, Emtech, Pacific Coast Labs, Westone

*Note: Contracts have been established only with the previously listed vendors. If an off-contract vendor is required to appropriately fit the child, please call to discuss alternatives.*

2. Complete the following information for the child's hearing aids.

**Number of Hearing Aids Requested**       1       2

Hearing Aid: \_\_\_\_\_ (Manufacturer) \_\_\_\_\_ (Model)

Earmolds \_\_\_\_\_ (Manufacturer)

Comment regarding preference: \_\_\_\_\_

3. Request \$150 fitting fee?  Yes  No *(Fee only allowed if not covered by other payor or agency.)*

4. Fax *both* sides of this form to HEAR for Kids at (602) 296-0425.

5. If you have questions call Lylis Olsen at (602) 690-3975 or email [lylisolsen@msn.com](mailto:lylisolsen@msn.com)

6. HEAR for Kids® will fax or email authorization with account and PO numbers, usually within 48 hours.