THE EAR FOUNDATION® OF ARIZONA

Support From Vitalyst HEALTH FOUNDATION A CATALYST FOR COMMUNITY HEALTH

HEAR for Kids

Parent/Guardian Please Complete this Section

Child's Name: _____ Date of Birth: _____

Home Address: _____

Birthing 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$100x 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_____

Hearing Aids/CI Processer or Repairs

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 06/16).

Number in Family	*Annual Income*	*Number in Family*	*Annual Income*	*Number in Family*	*Annual Income*
1	*$17,655*	3	*$30,135*	5	*$42,615*
2	*$23,895*	4	*$36, 375*	6	*$48, 855*

For each additional person, add $6,240

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 authorization will be emailed to the audiologist. Order using EFAz Purchase Order and Account # but ship to you. If the family does not meet the qualifications but there are special circumstances, call Lylis Olsen at (602) 753-5273.

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, Cochlear
   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/CI: _____ (Manufacturer) _____ (Model)
   Earmolds _____ (Manufacturer)
   Repairs to Hearing Aids or Cochlear Implant parts to be ordered_____
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) 753-5273 or email HEARforKids@earfoundationaz.com.
6. HEAR for Kids® will fax or email authorization with account and PO numbers, usually within 1 week.