Center for Deaf and Hard of Hearing Education

haapi hearing aid assistance program of indiana

administered by hear indiana

Indiana State Department of Health

AUDIOLOGIST REGISTRATION
REVISED 7/26/2018

Note: Each audiologist who is interested in participating in HAAPI must complete a separate registration form, even if another audiologist within the same facility has already done so.

AUDIOLOGIST INFORMATION

Audiologist Name _____ Audiologist Email _____

Indiana License Number _____

Facility Name _____

Facility Owner/Director _____

Address _____

Phone Number _____ Email Address _____

Contact Person _____ Contact Email _____

PROGRAMMING INFORMATION

Which of the following do you have the software to program?

Traditional Hearing Aids

☐ Oticon ☐ Phonak ☐ Siemens ☐ Other _____

Bone Anchored Hearing Aids

☐ Oticon Medical ☐ Cochlear

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REQUIRED DOCUMENTS

☐ By initialing here I indicate understanding that my registration will not be accepted until the following documentation has been received:

☐ Valid Indiana License ☐ Proof of Professional Liabiligy Coverage ☐ E-Payment Form ☐ W-9

As a HAAPI Participating Audiologist, I agree to the following:

• I hold a current Indiana licensure in audiology, and will maintain an unrestricted Indiana license at all times while participating in HAAPI.

• I currently have and will maintain professional liability insurance at all times while participating in HAAPI. I understand that all clinical decisions regarding hearing aids and all professional services are my responsibility, and that neither HAAPI nor the HAAPI administrators have any healthcare provider relationship with my patients.

• I understand that my Participating Audiologist Registration Forms must be accepted prior to submitting my first hearing aid order through HAAPI.

• I will assist the family with applying to HAAPI. I understand that the family's application must be approved prior to ordering a hearing aid through HAAPI on behalf of a family.

• I understand that the family must submit an audiogram completed within six months and a medical clearance signed by a physician dated within six months of the date the application is received.

• I have reviewed the American Academy of Audiology (AAA) and the American Speech-Language-Hearing Association (ASHA) clinical practice guidelines on pediatric amplification and agree to abide by the audiological best practices listed therein. (A copy of these guidelines is available at HAAPIndiana.org/AAAguidelines.)

• I will select the most appropriate FM compatible hearing aid from the approved list taking fitting range into account.

• I understand that HAAPI will cover up to $1600 per ear for the hearing aid, which includes a 3-year warranty, an earmold, and a pediatric care kit that I agree to pass along to the patient at time of fitting.

• I understand that HAAPI will pay a fitting fee of $400 for one ear or $600 for two ears and I agree not to charge the patient for the fitting If I accept the $400 per ear fee from HAAPI.

• I understand that I will not make a profit on the aids/molds obtained through this program by collecting deductibles, insurance payments, or balance billing the family for services provided.

• I understand that I CAN charge the patient for follow-up services (e.g., hearing aid adjustments) in accordance with my usual and customary rates. I will clearly explain these fees (if applicable) to the family before ordering the device.

• I agree to return aids to the manufacturer (crediting the HAAPI account) if the aid is not dispensed or if it is returned for some reason.

Authorized Signature Date

Email, scan, fax, or mail this application and supporting documents to:

Hear Indiana
ATTN: HAAPI
4740 Kingsway Dr., Ste. 33
Indianapolis, IN 46205

info@HAAPindiana.org
Fax: 888-887-0932
Questions? Call 317-828-0211