



APPLICATION
 REVISED 7.1.18

PATIENT INFORMATION

Today's Date _____

Name _____ DOB _____ Gender: Male Female Ethnicity _____

Address _____

Parent/Guardian Name _____ Phone Number _____

Email Address _____ Number of People in Household _____

- Household Income:
- | | | | |
|---|--|--|---|
| <input type="checkbox"/> Less than \$10,000 | <input type="checkbox"/> \$30,001-\$40,000 | <input type="checkbox"/> \$60,001-\$70,000 | <input type="checkbox"/> \$90,001-\$100,000 |
| <input type="checkbox"/> \$10,001-\$20,000 | <input type="checkbox"/> \$40,001-\$50,000 | <input type="checkbox"/> \$70,001-\$80,000 | <input type="checkbox"/> \$100,000 or More |
| <input type="checkbox"/> \$20,001-\$30,000 | <input type="checkbox"/> \$50,001-\$60,000 | <input type="checkbox"/> \$80,001-\$90,000 | |

HEARING HISTORY

Age of Identification _____

Newborn Hearing Screening: Pass Fail Unknown

Degree of Hearing Loss **Type of Hearing Loss**

- | | | | |
|--------------------------|--------------------------|--------------------------|--------------------------|
| L | R | L | R |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| None | | None | |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Mild | | Sensorineural | |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Moderate | | Conductive | |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Severe | | Mixed | |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Profound | | Auditory Neuropathy | |

DEVICE & COMMUNICATION

Does the child currently have hearing aids? Yes No

Age of hearing aids in years: 0-3 4-6 7+

Current Status: Working Broken Lost

Other _____

What is the family's chosen mode of communication?

- Spoken Language Sign Language
 Total Communication Cued Speech

SCHOOL INFORMATION

Grade _____

School Name _____

School District _____

Student has a(n): IEP 504 Plan Neither

School accommodations and services received:

- Extended Time FM System Preferential Seating

Other: _____

PROVIDER INFORMATION

Last Audiologist Seen _____

Phone Number _____

Participates in the HAAPI Program? Yes No

If No, who is your HAAPI Participating Audiologist?

Name _____

Phone Number _____

HEARING AID REQUEST

- Unilateral (1) Hearing Aid (one earmold and pediatric care kit included)
 Bilateral (2) Hearing Aids (two earmolds and pediatric care kit included)

Requested make, model, power level & battery size

Right _____

Left _____

Reason for requesting this make/model _____

PROGRAM INFORMATION

Have you received hearing aids through HAAPI in the past? Yes No

If yes, when did your child receive hearing aids through HAAPI? _____

REFERRAL INFORMATION

How did you hear about this program?

- Flyer Online Search Audiologist Speech Therapist School Teacher of the Deaf
 Other (Please Describe): _____

REQUIRED DOCUMENTS

Please remember applications will be processed in order of completion only after all required documentation has been received.

I understand this application will not be processed without the following documentation:

- Medical Clearance for Hearing Aids Recent Audiogram
 Birth Certificate or Proof of School Enrollment

- I affirm that all the information in this application is true to the best of my knowledge. I understand that all information here will be shared with the Indiana State Department of Health.
- I understand that HAAPI administrative staff will discuss my application with the audiologists listed on this application and that this release does not permit the disclosure of these records to any other persons or entities without my written consent or as permitted by law.
- I understand that HAAPI only covers approved hear aids, earmolds, and fitting fee. Any follow up appointments will be billed to my insurance.
- I understand that audiologists will NOT bill me for hearing aids, fitting fees, or my insurance deductible.

Parent/Legal Guardian 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