Center for Deaf and Hard of Hearing Education

haapi hearing aid assistance program of indiana

administered by hear indiana

Indiana State Department of Health

APPLICATION

REVISED 7.26.18

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:

☐ Less than $10,000
☐ $10,001–$20,000
☐ $20,001–$30,000
☐ $30,001–$40,000
☐ $40,001–$50,000
☐ $50,001–S60,000
☐ $60,001–$70,000
☐ $70,001–$80,000
☐ $80,001–$90,000
☐ $90,001–$100,000
☐ $100,000 or More

HEARING HISTORY

Age of Identification _____

Newborn Hearing Screening: ☐ Pass ☐ Fail ☐ Unknown

Degree of Hearing Loss			Type of Hearing Loss	
L	R		L	R
☐	☐	None	☐	☐ None
☐	☐	Mild	☐	☐ Sensorineural
☐	☐	Moderate	☐	☐ Conductive
☐	☐	Severe	☐	☐ Mixed
☐	☐	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 (one earmold and pediatric care kit included)

Requested make, model, power level & battery size

Right _____ Left _____

Reason for requesting this make/model _____

_____

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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 dated within 6 months of application date.

☐ Audiogram dated within 6 months of application date.

☐ Birth certificate for children not yet in kindergarten or proof of school enrollment for school age children.

• 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