4280 Hale Parkway • Denver CO • 80220
303-751-2519 • www.hearproject.org

H.E.A.R. PROJECT

APPLICATION FOR ASSISTANCE

TO BE COMPLETED BY AUDIOLOGIST

Audiologist Information

Name of Audiologist: _____ Date: _____

Colorado License #: _____ Name of Practice: _____

Address of Practice: _____

City: _____ State: _____ Zip Code: _____

Phone #: _____ Fax #: _____ Email :_____

Patient Information

Child's Name: _____ DOB: _____

Pre-existing Medicaid Patient? ___Yes ___No

If yes, Medicaid Number: _____

Does patient have private insurance? ___Yes ___No

If yes, were they denied coverage? ___Yes ___No

If yes is there a high deductible or other financial hardship? ___Yes ___No

If yes, please explain: _____

_____

_____

Please explain why you are recommending this child for HEAR Project funding. Attach extra sheets if necessary.

_____

_____

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Audiologic Information

Degree of hearing loss:

Right: ___Mild ___Moderate ___Severe ___Profound

Left: ___Mild ___Moderate ___Severe ___Profound

Type of hearing loss:

Right: ___Conductive ___Sensorineural ___Mixed ___Auditory Neuropathy

Left: ___Conductive ___Sensorineural ___Mixed ___Auditory Neuropathy

Hearing loss has been: ___Stable ___Progressive ___Fluctuating

Most recent hearing aid fitting date: _____

Currently wearing: ___BTE ___Open Fit ___RIC ___CIC ___ITE

___None Other_____

Current fit is: _ __Binaural ___Right ear only ___Left ear only ___CROS ___Other

Reason for refit: _____

In which ear is a hearing device being requested: ___Left ___Right ___Both

Has child been fit with amplification on a trial basis? ___Yes ___No

Please include a copy of the current audiogram taken within 6 months, physiologic test results, physician visit forms and any other pertinent audiological information needed for diagnosis with this request. Anything else we should know? Attach extra sheets if necessary.

_____

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The HEAR Project provides new hearing aids and also considers requests small grants for hearing aid repairs, earmolds, and other services. Please indicate below the option for which you are which option you are applying and provide appropriate explanation

___Hearing aids ___Small grant funding

Hearing Aids

We provide hearing aids from Oticon and Phonak. All aids also come with a Patient Care Kit. The HEAR Project understands that every child has individual requirements. We are seeking to fund as many children as possible. Please be mindful of this when making hearing aid recommendations/requests.

Hearing aid make, model, and preferences: _____

_____

_____

Delivery details:

Name: _____

Address: ___Same practice as above ___Other

Other Address: _____

City: _____ State: _____ Zip Code: _____

Small Grant Funding: If you are requesting small grant funding please explain below:

_____

_____

_____

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_____

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_____

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Documentation

PLEASE SEND THE FOLLOWING REQUIRED DOCUMENTS

Please send copies – originals will not be returned

___Audiogram and appropriate records

___Copy of Medicaid card (if applicable)

___Copy of denial insurance denial of hearing aid coverage (if applicable)

By printing your name below, you affirm that the information contained within this application is current and complete. If a change in any information occurs, please notify HEAR Project immediately. Additionally, I grant permission to the The Hear Project to release all medical records pertaining to my patient's hearing disorders to the assigned HEAR Project Coordinator for the purposes of applying for alternative financial assistance.

Upon acceptance as a hearing aid provider for the HEAR Project, you agree to the following terms:

a) To recommend and fit the optimum amplification that is most appropriate for each child or infant seeking funding.
b) To schedule all eligible children/infants as soon as possible to expedite fitting of hearing aid amplification.
c) To return the hearing aid(s) purchased by HEAR Project to HEAR Project if a patient is no longer in need of the hearing aids. The hearing aids will be used as loaners for other children.
d) To notify HEAR Project Coordinator immediately if a change in any information occurs and/or you receive any additional information regarding your patient's BCMH/Medicaid approval/denial status or any other third party funding status.

Signature of Provider: _____ Date: _____

Printed Name: _____

****** Form can be emailed to applications@hearproject.org, and can also be faxed to: 303-751-2519******

The HEAR Project reserves the right to change the eligibility criteria at any time without written notification. The program will provide funding for hearing aid amplification as long as the funds for the program are available.