CHILDREN'S HEARING AID PROGRAM (CHAP) UCA 26-10-11
AUDIOLOGIST APPLICATION

Thank you for choosing to participate with the Children's Hearing Aid Program (CHAP) to provide amplification for eligible infants and toddlers up to age 6 years. Please complete all required documents listed below, and return to the CHAP office by fax: (801-584-8492) or mail: CHAP, PO Box 144620, Salt Lake City, Utah 84114-4620. Once received, applications will be reviewed and you will be notified whether the patient is eligible for participation.

Audiologist Name	**Agency**		
Address	**City**	**State**	**Zip**
Phone	**Email**		

Patient Name (LAST, FIRST, MIDDLE)			**Patient DOB**
Requested Hearing Instruments	**MAKE**	**MODEL**	**EAR (Circle one)** **RIGHT** **LEFT** **BINAURAL**

AGREEMENT

_____ I attest that I am a licensed audiologist and have the expertise and tools to properly fit quality digital hearing aids on infants and young children.

_____ I agree to follow best practice for fitting amplification on infants and young children, including real-ear measurements. The *Utah Recommended Audiological Assessment and Amplification Protocol* is available at www.infanthearing.org/stateguidelines/Utah/ut_audiology_protocols.doc or by calling CHSS at 801-584-8215.

_____ I agree to provide a fitting report and one year progress report for this participant to the CHAP committee.

_____ I understand that I must submit to CHAP *the PAYMENT REQUEST FORM* to include the following:

1. Original hearing aid invoice from the manufacturer indicating my actual cost. I will be reimbursed actual cost + 40%, in addition to the reasonable and customary fee for the hearing aid fitting.
2. Original ear mold invoice from the manufacturer with my usual and customary fee for ear mold fitting.
3. I will submit my/our *usual and customary* Clinic Price List that includes hearing aid and earmold fitting fees.
4. I agree to accept the amount listed above as payment in full, and will not bill patient for remaining charges associated with hearing aids, fitting fees, ear molds, and follow-up visits for a period of one year.

_____ I agree to provide real-ear measurements from the initial fitting obtained either via probe microphone or measured RECDs with S-REM.

_____ I agree to provide a two-year repair with loss and damage coverage per hearing aid.

_____ If/when these hearing aids are no longer appropriate for this patient, I agree to return them to the Children's Hearing and Speech Services, Hearing Aid Recycling Program (HARP) if possible.

_____ I understand that this patient may access hearing aids through CHAP one time only per ear prior to the sixth birthday.

_____ I have enclosed the required documents as indicated below. If this is not the initial fitting (for this child under the age of 6), and the child needs replacement hearing aids, I have included evidence as to why current amplification is no longer appropriate.

_____ I recommend this patient for the CHAP and believe the family to be responsible and attentive to the requirements necessary for the successful implementation of amplification.

_____**If the child is under three**, I attest that the family has been referred to and enrolled in a Part C Early Intervention Program.

_____ I have verified that the child applicant is a Utah resident and is under age six years of age at the time of application.

_____ I agree to complete CHAP surveys whenever requested.

REQUIRED DOCUMENTS FOR SUBMISSION:

- ☐ *PARTICIPANT APPLICATION*
- ☐ *AUDIOLOGIST APPLICATION*
- ☐ *CSHCN FINANCIAL FORM FOR CHAPP*
- ☐ Current Audiogram
- ☐ Statement of Medical Clearance
- ☐ Proof of Insurance Denial or Exclusion

Managing Audiologist Signature	**Date**