UTAH DEPARTMENT OF HEALTH

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

CHILD/FAMILY

Child's Name (LAST, FIRST, MIDDLE)		**Patient DOB**	**Gender**
Parent/Guardian (LAST, FIRST, MIDDLE)			
Address	**City**	**State**	**Zip**
County	**Email**		
Home Phone	**Work Phone**	**Cell Phone**	
Race (Circle all that apply) *Caucasian* *African American* *Native American* *Asian* *Pacific Islander* *Other* _ _ _ _ _ _ _ _ _			
Language(s) used in the home	**Ethnicity (Circle one)** *Hispanic* *Non-Hispanic*		

ALTERNATE CONTACT

Name (LAST, FIRST, MIDDLE)			
Address	**City**	**State**	**Zip**
Home Phone	**Work Phone**	**Cell Phone**	

MANAGING/REQUESTING AUDIOLOGIST

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

QUALIFICATIONS (parent/guardian initials required)

_____ I attest that that my child is a Utah resident and is less than six years old at the time of application.
_____ My child has been identified with permanent hearing loss by an audiologist with expertise in pediatric audiology.
_____ My child has received medical clearance by a medical provider for hearing aid fitting.
_____ I have applied for and been denied access to Medicaid, or my child is not eligible for Medicaid.
_____ I have investigated insurance coverage for hearing aids and been denied. (Proof of non-coverage is required.)
_____ I have submitted a CSHCN Financial Form (PFR) with this application.

CONSENT AND RELEASE (parent/guardian initials required)

_____ I understand that the CHAP will pay for my child's hearing aid(s) and also the ear molds needed in the first year. Payment will be made directly to my child's audiologist. Additional charges (such as follow-up fees, out-of-warranty repairs, batteries, battery tester, stethoset and additional ear molds) will be my responsibility.
_____ I agree to maintain routine and appropriate audiological follow-up for my child while hearing aids are provided by CHAP.
_____ If my child is under three yrs, I agree to enroll my child and actively participate in a Part C Early Intervention program.
_____ I agree to return the hearing aids to the Utah Department of Health for their Hearing Aid Recycling Program (HARP) if possible, when they are no longer necessary or appropriate for my child.
_____ I agree that if I claim loss and damage for hearing aids during the warranty period, I will secure a supplemental insurance policy for an additional one year.
_____ I agree to complete CHAP surveys whenever requested.
_____ I understand that information will be shared with others to facilitate the reporting process of the pilot program. Information sharing complies with privacy and security policies of the Utah Department of Health and is HIPAA compliant. No personally identifying information will be shared publicly without my written authorization.
_____ I understand that under the law, CHAP does not constitute a legal right or entitlement and may be withdrawn at any time without notice and without cause.

Parent/Guardian Signature (Please sign and submit to audiologist)	**Date**
Managing Audiologist Signature (Please sign and submit to CHAP)	**Date**
CHAP Authorized Signature *DENIED* *APPROVED* *Assigned CHAP #:*	**Date**
Additional Information Required *(for office use only)*	REV 5:070115