UTAH DEPARTMENT OF HEALTH

Hearing Aid Recycling Program (HARP)

A collaboration with Utah Families, Audiologists, and the Utah Dept. of Health

Name: _____ Date of Birth: _____
Last First Middle

Parent/Guardian Name: _____
Last First Middle

Address: _____ City: _____ State: _____ Zip:_____

Home Phone: _____ Work : _____ Cell: _____

Sex: ☐ F ☐ M

Race: ☐ Caucasian ☐ African American ☐ Native American ☐ Asian or Pacific Islander ☐ Other

Language Spoken in the Home: _____ Ethnicity: ☐ Hispanic ☐ Non-Hispanic

Alternate Contact:

Name: _____
Last First Middle

Address: _____ City: _____ State: _____ Zip:_____

Home Phone: _____ Work : _____ Cell: _____

Managing/Requesting Audiologist: _____
Name Agency

Address: _____ City: _____ State: ___ Zip:_____ Phone: _____

Release and Consent:

- I have applied for and been denied access to Medicaid.
- I have investigated insurance participation in hearing aid purchase and been denied. (Proof of denial or exclusion is required)
- I understand that information is collected and shared with others as necessary to facilitate the mutually agreed upon services and treatment. No information will be shared publicly without my family's written authorization.
- I agree to return hearing aids to the Utah Department of Health when they are no longer necessary/appropriate for my child.
- I agree to maintain routine and appropriate audiological follow-up for my child while fit with these hearing aids.

Signature: _____ Date: _____

Rev. June 2020