IOWA Health and Human Services

Hearing Aids and Audiological Services Application

NOTE: All fields in this application are **required** for processing.

A. Patient Information

Patient's Name (First, Middle Initial, Last)			**Patient's Date of Birth** (Mo, Day, Yr)
Address (Street, PO Box, RR or RFD. Apt. #)			
City	**State**	**Zip Code**	**Telephone Number**
Street, address and city where you actually live, if different from mailing address			
Parent/Guardian's Name (First, Middle Initial, Last)			**Parent/Guardian's E-mail Address**

B. Insurance Information

Do you have Medical Insurance?

☐ Yes ☐ No

1. If you answered **Yes** above; list the name of your Medical Insurance Company.	2. Do you have coverage for routine Hearing Aids through your medical insurance? (This would include policies with deductibles.) ☐ Yes ☐ No **Please send a copy of your Insurance Benefit Summary with this application as proof of the box chosen.**

1. If you answered **No** above; have you applied for Medicaid/Hawki within the last year? ☐ Yes ☐ No	2. Have you been denied from Medicaid/Hawki in the last year? ☐ Yes ☐ No **If you don't have Medical Insurance, you are required to have a Medicaid/Hawki Denial to be eligible for our funding. Please send a copy of the denial with your application.**

C. Audiological Provider Information

Audiologist's Name	**Clinic Location**
Provider Phone Number	**Have you had ever had an appointment with the provider listed above?** ☐ Yes ☐ No

A message to the parents:

Limited funding was made possible through an appropriation by the Iowa Legislature during the last legislative session. The intent of this funding is to provide payment for hearing aids and/or audiological services for children who otherwise would not be able to afford these services. We ask that you only apply for this program if the needed hearing aids and/or audiological services are not fully covered by another source and would produce an undue financial hardship for your family. Your consideration will ensure that the greatest number of children will be served by this funding. For a list of eligible audiological services, please review the Frequently Asked Questions link at: https://hhs.iowa.gov/programs-and-services/ehdi/funding.

My signature indicates that I agree that the information contained in this application is accurate and may be shared with the hearing aid or audiological services provider listed in this application for the purposes of payment.

Signature of Parent/Guardian	**Date**

Thank you for your interest in the Hearing Aids and Audiological Services Program!

Please mail or fax completed applications and required documents from **Section B: Insurance Information** to:

North Iowa Community Action
Hearing Aids and Audiological Services Program
P.O. Box 1627
Mason City, IA 50402-1627
Phone: (641) 424-8006
Fax: (833) 536-1806