SOUTH DAKOTA HEARING AID ASSISTANCE PROGRAM

The South Dakota Hearing Aid Assistance Program provides financial assistance for purchase of hearing aid(s) and associated ear mold(s) for eligible applicants less than 19 years of age.

Audiologist's Medical Information Form

APPLICANT INFORMATION

Name: _____

Address: _____

Date of birth: _____/_____/_____Age: _____

PROVIDER INFORMATION

Provider name: _____

Provider NPI (National Provider Identification) #: _____

State License #: _____

Phone number: _____ Fax number: _____

MEDICAL EVALUATION

As required by the FDA, a prospective hearing aid user must provide a written statement from a licensed physician that the prospective user has been medically evaluated and is a candidate for a hearing aid(s). A hearing evaluation must occur within 6 months prior to the date of purchase of the hearing aid(s). If 18 years of age or older, the prospective user may waive this requirement provided the prospective user signs a waiver statement. Children (age less than 18 years) are not eligible for a waiver.

I (*audiologist name)* _____will obtain the physician's medical clearance necessary for the hearing aid(s) fitting prior to the fitting.

HEARING EVALUATION

Date tested ____/____/_____

Type of loss: (check)

Sensorineural R___ L___	Conductive R___ L___	Mixed R___ L___	Auditory Neuropathy Spectrum Disorder R___ L___

Degree of hearing loss

Mild Hearing Loss:_____ *(20 TO 40dB HL)*	Moderate Hearing Loss:_____ *(40 to 60 dB HL)*
Severe Hearing Loss:_____ *(60 to 80 dB HL)*	Profound hearing loss (including deafness):_____ *(+80 dB HL)*

Diagnosis – Include an explanation of the particular problem resulting from the diagnosis which relates to this equipment request:

How long is this problem expected to last? Months_____ Indefinitely_____ Permanently_____

HEARING AID INFORMATION

Has consumer used a hearing aid in the past? Yes___ No___

Approximate age of old hearing aid: _____

EQUIPMENT

Manufacturer name: _____Style/model: _____

Hearing aid for: Right Ear___ Left ear___ Binaural____

Usual and Customary Cost of Equipment

Right ear	Left ear	Binaural

Usual and Customary Cost of Initial Ear Mold

Right ear	Left ear	Binaural

HEARING AID FITTING

I confirm that I will be doing Real Ear Verification: Yes_____ No_____

After evaluating this patient, I certify the need for the dispensing of a hearing aid(s)

Audiologist signature: _____ Date: ____/____/_____

Once approved, the Department of Human Services will authorize services to the audiologist. The authorization will include authorized dollar amount that will be paid to the provider.

FINANCIAL CONTRIBUTION

- The South Dakota Hearing Aid Assistance Program is the payer of last resort after private health insurance or other third party resource.
- The program will pay only for hearing aids and associated ear molds. It will be the responsibility of the provider to separate out any other applicable costs which will be the responsibility of the applicant.
- Payment will be made directly to the provider.
- Any applicable copayments are the responsibility of the consumer.
- To be eligible for a hearing aid(s), an individual must not have received a hearing aid(s) through this program or SD Medicaid within 3 years prior to the date of application.