DHS-HAAP-2023

DEPARTMENT OF HUMAN SERVICES

Application

Hearing Aid Assistance Program

APPLICANT INFORMATION

Applicant Name_____
First *MI* *Last*

SS#:_____ Date of Birth: _____ Gender: Male___ Female___

Has the applicant received hearing aid(s) from this program or SD Medicaid? Yes ☐ No ☐
If yes, when were the hearing aid(s) received? Date_____

Parent/Guardian Name(s): _____

Mailing Address _____

City_____ State_____ Zip_____

County_____ Email Address _____

Primary Phone _____ Secondary Phone_____

ELIGBILITY

The following criteria must be met to be eligible for the Hearing Aid Assistance Program

- Be a resident of South Dakota
- Be under 19 years old
- Have progressive or permanent hearing loss which requires hearing aids
- Have not received hearing aid(s) from this program or SD Medicaid within 3 years of this application
- Meet financial eligibility

HEALTH INSURANCE

Does the applicant have Medicaid coverage? Yes ☐ No ☐

Is the applicant covered under a Health Insurance Plan? Yes ☐ No ☐

Has coverage been approved or denied for the requested services? Approved ☐ Denied ☐

INCOME

Household income includes all income, earned and unearned, from all individuals that reside in the household.

Accepted forms of income verification include:

1. Most recent federal tax form (1040 Tax Return) is preferred, or;
2. Income or wage statements (Examples include pay statements, social security, unemployment, public assistance, or other statements verifying money received by the family). Include at least three consecutive with this application. *Note: If one or more family members are currently employed in seasonal employment, last year's tax return is required rather than monthly income.

Total Number of Members in Household:_____

Type of Income	Annual Amount
Gross wages	
Self-Employment	
Social Security, SSI or SSDI	
Pensions	
Public Assistance	
Unemployment/ Worker's Compensation	
TOTAL	

2023 Federal Poverty Guidelines			
Household Size	**200%**	**300%**	**400%**
1	$29,160	$43,740	$58,320
2	$39,440	$59,160	$78,880
3	$49,720	$74,580	$99,440
4	$60,000	$90,000	$120,000
5	$70,280	$105,420	$140,560
6	$80,560	$120,840	$161,120
7	$90,840	$136,260	$181,680
8	$101,120	$151,680	$202,240
More than 8 add the below figure for each additional person			
	$10,280	$15,420	$20,560
% of Poverty Level	=<200%	201% - 300%	301% - 400%
% of financial contribution provided by DHS			
	100%	75%	50%

DHS provides financial assistance for hearing aids and initial ear molds only. Pre-approval is required, and payment is made directly to the facility. All other fees are the responsibility of the consumer. Percent of cost covered is determined by household size and income on a sliding fee scale according to the table above.

Upon approval of this application, I agree to the following:

a) To be responsible for the daily care, maintenance, batteries, and replacement ear mold(s).
b) To accept the terms of payment for any audiological services not covered by the program (fitting/dispensing, replacement ear mold(s), follow-up visits).
c) Make payment directly to the audiologist for any applicable balance not covered by the financial contribution provided by the program.

I affirm that the information provided is complete and correct to the best of my knowledge.

_____ _____
Applicant Signature if 18 Date

_____ _____
Parent/Guardian Signature Date

Submit **application**, **income documentation**, and **audiologist form** to:

Shayna Remund
Division of Rehabilitation Services
1310 Main Ave S, Suite 102
Brookings, SD 57006
Fax: 605-688-5497
Shayna.Remund@state.sd.us

Hearing Aid Assistance Program Audiologist Form

This section must be completed by the facility or audiologist dispensing the hearing aid(s)

APPLICANT INFORMATION

Name: _____Date of Birth:_____

Parent/Guardian Name(s):_____

Address: _____City:_____State:_____Zip:_____

PROVIDER INFORMATION

Facility name: _____

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 of evaluation: _____

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 barriers resulting from the diagnosis as it relates to this equipment request

How long is this 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

☐ I confirm that I will be doing Real Ear Verification

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

Audiologist signature: _____ Date: _____

Upon application approval, the Department of Human Services will provide an authorization with the authorized dollar amount the applicant qualifies for 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 resources.
- The program only covers the cost of the hearing aids and initial ear molds. It is the responsibility of the provider to separate out any other applicable costs, including fitting and dispensing fees, which will be the responsibility of the consumer.
- Payment will be made directly to the provider. Prior authorization is required.
- Any applicable copayments are the responsibility of the consumer.