South Dakota Hearing Aid Assistance Program
Application Form

South Dakota Department of Human Services, Division of Rehabilitation Services

Personal Information

Name: _____Date of Birth:_____Gender: Male ☐ Female ☐

SS#: _____ Parent(s) Name: _____

Street Address: _____ City/St/Zip: _____

County of Residence:_____ Email Address: _____

Home/ Cell Phone Number: _____ Work Number: _____

Has applicant ever worn hearing aid(s)? Yes ☐ No ☐

If yes, did applicant receive hearing aid(s) from this program or SD Medicaid? Yes ☐ No ☐

If yes, when were these hearing aid(s) received? Date:_____

Eligibility

To be eligible for the Hearing Aid Assistance Program, the individual must meet the following criteria:

- The individual must be a resident of South Dakota;
- The individual must be under 19 years of age;
- The individual must have a progressive or permanent hearing loss which requires hearing aid(s);
- The individual must not have received a hearing aid(s) from this program or SD Medicaid within 3 years prior to the date of application; and
- The individual must be financially eligible.

Insurance Coverage

The Hearing Aid Assistance Program is the payer of last resort. An applicant must utilize any private health insurance as well as all other third party resources before being eligible for this program.

Is the applicant covered for hearing aid(s) under Medicaid or Health Insurance Plan? Yes ☐ No ☐

If yes
Name of Insurance: _____Phone:_____

If insurance does not cover the entire cost of the hearing aid(s) and associated ear molds, the Hearing Aid Assistance Program will cover any remaining costs in accordance with the program rules and sliding fee scale. Please provide any relevant coverage information along with this application.

Income

List monthly income for all members within the current household. Complete the table below and identify each household member with income.

Accepted forms 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 ones 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.

South Dakota Hearing Aid Assistance Program Sliding Fee Scale

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	

2022 Federal Poverty Guidelines			
Family Size	**200%**	**300%**	**400%**
1	$27,180	$40,770	$54,360
2	$36,620	$54,930	$73,240
3	$46,060	$69,090	$92,120
4	$55,500	$83,250	$111,000
5	$64,940	$97,410	$129,880
6	$74,380	$111,570	$148,760
7	$83,820	$125,730	$167,640
8	$93,260	$139,890	$186,520
More than 8- add the below figure for each additional person			
	$9,440	$14,160	$18,880
% of Poverty Level	=<200%	201% - 300%	301% - 400%
% of financial contribution provided by Program			
	100%	75%	50%

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.

Signature of Parent/Guardian:_____ Date: _____

Or if the applicant is at least 18 years of age

Signature of Applicant:_____ Date: _____

Please return this form via mail, fax or email to:

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

To determine eligibility, the Division of Rehabilitation Services must receive the following information:

- A completed application form.
- Verification of household gross income.
- A Medical Clearance, Evaluation and Prescription form completed by the audiologist.
- Any applicable insurance coverage.

Revised 01/2020

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.