



Mariannette Miller-Meeks, B.S.N., M.Ed., M.D.  
 Director

Terry E. Branstad  
 Governor

Kim Reynolds  
 Lt. Governor

## Hearing Aids and Audiological Services Application

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

*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.*

*Please print when completing the application.*

<b>Patient Eligibility Number (filled in by Provider Claim Systems, if initial application):</b>			
<b>Patient's Name</b> (First, Middle Initial, Last):		<b>Patient's Date of Birth</b> (Mo, Day, Yr):	
<b>Address</b> (Street, PO Box, RR or RFD. Apt. #):			
<b>City:</b>	<b>State:</b>	<b>Zip Code:</b>	<b>Telephone Number:</b>
<b>Street, address and city where you actually live, if different from mailing address:</b>			
<b>Parent/Guardian's Name</b> (First, Middle Initial, Last):		<b>Insurance:</b> <input type="checkbox"/> <b>Yes</b> <input type="checkbox"/> <b>No</b> , must provide a copy of <b>Medicaid/hawk-i</b> denial	
<b>Parent/Guardian's E-mail Address:</b>			
<b>Insurance Plan Name</b> (e.g. Blue Cross Blue Shield, Medicaid/hawk-i):			
<b>Hearing Aid/Audiological Services Provider Name</b>		<b>Service Provider Telephone Number:</b>	

## Hearing Aids and Audiological Services Application

I would like assistance with the following:

- Hearing Aid(s):             Unilateral (one)     Bilateral (two)     Ear Molds
- Hearing Assessment     FM system             Repair
- Other, please list \_\_\_\_\_

Funding does not cover the surgical costs associated with a cochlear implant or Baha and cochlear implant to Baha device.

My signature indicates that I agree that the information contained in this application 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

Please mail or fax completed applications to:

**Provider Claim Systems**  
**PO Box 1608**  
**Mason City, IA 50402-1608**  
**Fax: (641) 422-2713**  
**Phone: (800) 547-6789**

### **641—3.20(82 GA, HF811) Appeals.**

The department shall cause an applicant to be notified of the department's decision to approve or deny an application or to place an applicant on the child hearing aids and audiological services waiting list. In the event an applicant is dissatisfied with the department's decision, the applicant may submit a formal appeal in writing to the EHDI advisory committee. Such request shall be delivered in person or shall be mailed by certified mail, return receipt requested, to EHDI Advisory Committee, Iowa Department of Public Health, Lucas State Office Building, 321 E. 12th Street, Des Moines, Iowa 50319. Upon receipt of such an appeal, the EHDI advisory committee shall review the case and issue a written determination within 15 days of receipt of the request. The decision shall refer to the applicant by initials or other nonidentifying means. The EHDI advisory committee's decision shall be final and binding. This appeal process does not constitute a contested case proceeding as defined in Iowa Code chapter 17A.