

MARYLAND STATE DEPARTMENT OF EDUCATION
Division of Early Intervention and Special Education Services
MARYLAND HEARING AID LOAN BANK
HEARING AID LOAN APPLICATION FORM

The purpose of this program is to provide temporary hearing aids for children under the age of 18 with hearing loss while they are waiting to receive their personal amplification devices. The best way to contact the HALB is through email. Please contact the Hearing Aid Loan Bank at zella.shabasson@maryland.gov if you have any questions.

Please complete Parts A-D of this application and return to:

Maryland State Department of Education
Division of Early Intervention and Special Education Services
200 West Baltimore Street, 9th Floor
Baltimore, Maryland 21201
ATTN: Zella Shabasson
Email: zella.shabasson@maryland.gov
Fax: (410) 333-0298

The information contained on this form will be kept confidential.

PART A

Referring Audiologist Information

Audiologist Name: _____

MD Audiology License # _____

Mailing Address: _____

Phone Number: _____ Fax Number: _____

Email address: _____

Child's Information

Name: _____ Date of Birth: _____

Parent/Legal Guardian's Name: _____

Mailing Address: _____

Home #: _____ Cell phone #: _____ Email: _____

PART B - To be completed by the referring audiologist

In order for this request to be processed, a copy of any audiologic testing, medical clearance from the child's ENT, and an agreement form signed by the parent or legal guardian must be provided with this application. Please make copies or fax, as this paperwork will not be returned.

Was this child referred to you based results from the Universal Newborn Hearing Screening protocol? Yes ___ No ___ If yes, from which hospital _____

Was this child referred to you based upon results of a routine school screening program? Yes ___ No ___ If yes, from which school system _____

What is the configuration and degree of hearing loss?

Is this a binaural or monaural fitting? _____

Please indicate the make and model of hearing aid that you would recommend for this child, numbering preferences 1-3. While we cannot guarantee the exact make and model, please be assured that every attempt will be made to match your request.

1 _____ 2 _____

3 _____

The hearing aid(s) will be sent to the requesting audiologist following receipt of the application and required documentation, and based upon hearing aid availability. The hearing aid will be selected and sent by the Hearing Aid Loan Bank Director based on the information received.

Audiologist Signature

Date

PART C - To be completed by the parent or legal guardian

1. Please describe why you cannot obtain permanent hearing aids for your child at this time.

2. Do you currently have insurance coverage to secure permanent hearing aids for your child? If yes, have you contacted your insurance company to apply for hearing aids? **Please indicate the insurance company name, and the status of your contact.**

3. Are you currently eligible for Medical Assistance? If yes, have you contacted Medical Assistance to apply for hearing aids?

4. Do you need information regarding resources to secure permanent hearing aids?

5. For children under age 3, is your child currently enrolled in the Infants and Toddlers Program in your local county?

Yes _____ No _____ If yes, please indicate the county program _____

Parent/Legal Guardian Signature

Date

PART D - To be completed by the parent or legal guardian

HEARING AID LOAN AGREEMENT

_____ I AGREE THAT MY CHILD WILL RECEIVE (A) LOANED HEARING AID(S) FROM THE MARYLAND STATE DEPARTMENT OF EDUCATION, DIVISION OF EARLY INTERVENTION AND SPECIAL EDUCATION SERVICES.

_____ I AGREE TO PROVIDE A BRIEF STATEMENT INDICATING THE REASON ASSISTANCE FROM THE LOAN BANK IS REQUESTED.

_____ **I AGREE THAT IT IS MY RESPONSIBILITY TO MAINTAIN AND CARE FOR THE HEARING AID(S) AND THAT I WILL BE RESPONSIBLE FOR ANY LOSS OR DAMAGE NOT COVERED BY THE HEARING AID WARRANTY UP TO \$150.00. THIS EXCLUDES NORMAL WEAR AND TEAR.**

_____ I AGREE THAT MY CHILD WILL HAVE USE OF THIS/THESE HEARING AID(S) FOR UP TO 6 MONTHS. IF MY CHILD HAS NOT RECEIVED HIS/HER PERSONAL AMPLIFICATION WITHIN THAT TIME, I MAY EXTEND THE LOAN PERIOD BY 3-MONTHS, BY COMPLETING AN EXTENSION AGREEMENT.

_____ I AGREE TO SEEK PERMANENT HEARING AID(S) OR COCHLEAR IMPLANT FOR MY CHILD.

_____ I AGREE THAT WHEN MY CHILD RECEIVES HIS/HER PERSONAL AMPLIFICATION, I WILL RETURN THE LOANED HEARING AID(S) TO MY CHILD'S AUDIOLOGIST, TO BE RETURNED TO THE LOAN BANK.

Parent/Legal Guardian Signature

Date