Virginia Hearing Aid Loan Bank Application

Virginia Department of Health
Office of Family Health Services
Virginia Early Hearing Detection and Intervention

The purpose of this program is to provide temporary hearing aids and/or FM systems for children with hearing loss, who are under the age of 18, while they are waiting to receive their personal amplification devices. The instruments will be sent to the facility ***within 5 days*** of receiving the application and required documentation. The hearing aid will be selected based on the information received, in consultation with the child's audiologist.

Audiologist Name: _____

Practice Name: _____

Federal ID#: _____ VA Audiology License #: _____

Mailing Address: _____

_____

Phone Number: _____ Fax Number: _____

Audiologist Email: _____

Child's Name: _____ Date of Birth: _____

Fitting Date: _____

Parent/Legal Guardian's Name: _____

Mailing Address: _____

_____

City/County of Residence: _____ Phone Number: _____

Email: _____

I certify this child is my patient, is under the age of 18 and has a diagnostic testing to verify a hearing loss that requires a hearing device.

_____ _____

Audiologist Signature Date

Blue Ridge Care Connection for Children
Lisa Powley, 2205, Fontaine Ave, STE 201, Charlottesville, VA 22903
Phone: (434) 924-0222 Fax: (434) 924-0390 Toll free: (866) 596-9367 Email: vhalb@virginia.edu

Revised 2.2021

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_____ I agree that my child will receive loaned hearing aid(s) and/or FM system(s) from the Virginia Department of Health, Office of Family Health Services, Virginia EHDI Hearing Aid Loan Bank Program.

_____ I agree that it is my responsibility to take care of the hearing aid(s) and/or FM system(s) and that I may be responsible for payment of $150.00 for the device. This does not include normal wear and tear.

_____ I agree that my child can use this/these hearing aid(s) and/or FM system(s) for up to twelve (12) months while in the process of obtaining their own devices. An extension of up to three (3) months may be possible under certain circumstances and if a loan extension is submitted to your audiologist.

_____ I agree to return the devices to my audiologist when my child receives their own devices or at the end of the three (3) month loan period.

Do you have insurance? Yes ☐ No ☐

Medicaid/ FAMIS ☐ Private Insurance ☐ Only Partial Coverage☐ Other _____

_____ _____
Child's Name Date of Birth

_____ _____
Signature of Parent/Legal Guardian Date

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Hearing aid and FM systems

(For audiologist use: select device)

Please indicate if monaural or binaural:

Monaural ☐

Binaural ☐

Please indicate your first and second equipment choice:

1st: _____

2nd: _____

Phonak

Hearing Aids

Sky B50 P ☐

Sky B50 SP ☐

Sky B50 UP ☐

Sky M50M ☐

Sky M50 PR ☐

Sky M50 SP ☐

Sky Q 50 SP ☐

Sky Q 50 UP ☐

Roger Select ☐

Roger Pen ☐

Roger Touch Screen Mic ☐

Oticon

Hearing Aids

Oticon ☐

Sensei ☐

Sensei SP ☐

Siya 2 ☐

OPN Play 2 ☐

Xceed Play 1 ☐

Xceed Play 675 ☐

Connect Clip ☐

Sound Fields

Phonak Digimaster ☐

Lightspeed 750 IR ☐

FM System

Inspiro (Phonak) ☐

Amigo (Oticon) ☐