VDH VIRGINIA DEPARTMENT OF HEALTH
Office of Family Health Services

EHDI VIRGINIA

COMMONWEALTH OF VIRGINIA HEARING AID LOAN BANK APPLICATION

VIRGINIA DEPARTMENT OF HEALTH

OFFICE OF FAMILY HEALTH SERVICES

VIRGINIA EARLY HEARING DETECTION AND INTERVENTION PROGRAM

The purpose of this program is to provide temporary hearing devices for children with in the Commonwealth of Virginia, who are under the age of 21 years, diagnosed with a hearing loss. These devices are **TEMPORARY** and maybe used while parents/guardian are working to obtain funding to purchase aids for their child. The instruments will be sent to the facility within 5 days of receiving the application and required documentation. The hearing aid will be selected on the information received, in consultation with child's audiologist. Audiologist are responsible for keeping track of the child and returning the hearing devices at the end of the loan period.

Audiologist Name: _____

Name of practice: _____

Federal ID#; _____ VA Audiology License# _____

Mailing address for practice: _____

_____

Office Contact person for Billing and receiving aids: Name: _____

Email address: _____ Phone number: _____

Fitting Date: _____ End of Loan Period: _____

Why are you requesting loaner aids for this child?

_____

_____

Family Information:

Child's name: _____ Date of Birth: _____

Child Address: _____

With whom does the child reside: _____

Name & address of Parent/Legal Guardian: _____

_____

Phone number: _____ email address: _____

County: _____

Mother Place of employment: _____

Address of employer: _____

Phone number of place of employment: _____

Dad's place of employment: _____

Phone number of employer: _____

Is your child covered under private insurance? _____

Name of insurance: _____

Are hearing devices for your child covered under your plan? _____

Does your child have Medicaid? _____ Medicaid number: _____

What are your plans for obtaining permanent aids for your child after the loaner period is up:

_____

_____

Emergency Contact for child other than parents: _____

Phone number: _____ email address: _____

Physical address: (No PO Box number) _____

School Information

Name of school in which child is enrolled: _____

Address _____

Name of current teacher: _____

Email address; _____

Phone number: _____

Does the child have an: IEP: _____ or 504 Plan: _____

Is child enrolled in Early Intervention or Infant Toddler? _____

Does the child have an IFSP in place: _____

Guardian's Consent and responsibilities

I, _____ legal guardian of _____ give permission for _____ (Audiologist) to request/borrow loaner Hearing Aids from the Commonwealth of Virginia Loaner Hearing Aid Program. I will accept the responsibility of returning the hearing aids to _____ (audiologist) once my child permanent aids are fitted. I understand if my child should lose or misplace the hearing aids during the loaner period I am responsible for paying a $175.00 to Commonwealth of Virginia Loaner program. If family does not pay the $175.00 for lost aid or does not return the aids, the Commonwealth of Virginia Loaner Aid Program will offset the $175.00 by withholding funds from your State of Virginia Tax Refunds.

I understand it my responsibility to notify the Commonwealth of Virginia Loaner Program if aids are lost, destroyed or damaged during loaner period. If I change my address or move out of the Commonwealth of Virginia

_____ Signature of Guardian

Responsibility of Audiologist:

I am requesting the use of loaner aids for _____, I understand it is my responsibility to follow up with family to ensure aids are working properly. If not I am to return to the Commonwealth of Virginia Loaner Program for new aids. I am to return the aids to the Loan Bank at the end of the loaner period. If funds have not been secured to purchase aids for child by the family, it is my responsibility to request an extension period for the loaner aids.

_____ Signature of Audiologist