Wyoming Children's Hearing Aid Program (WYCHAP)

Dear Parent/Guardian;

The WYCHAP is a fund that was established in 2012 by the Wyoming Legislature. The goal of WYCHAP is to provide timely access to hearing aids (fit using best practice recommendations) for children, ages birth through the end of their high school career, identified with hearing loss who are either not insured or under-insured. The funds are limited, distributed on a first-come first-serve basis, and availability of funding is dependent upon future legislative action. **Please review "Factors to Consider Before Applying for WYCHAP Funding" on page 9 with the audiologist before filling out the application.**

Because parents/guardians are the best advocates for their children WYCHAP is placing the primary responsibility on you for ensuring that this application is complete. Please share this page with your audiologist and work with him/her to be certain all required materials are submitted in a timely fashion. Get the required audiometric data from the audiologist and submit all application materials at the same time.

Providing access to sound through the use of hearing aid technology addresses a single aspect of hearing loss. Receiving appropriate intervention services provided by qualified personnel and becoming connected with parent networks such as *Wyoming Families for Hands & Voices* help provide necessary support to families. You will notice that the Consent for Release/Exchange of Information Form includes a release to Early Hearing Detection and Intervention (EHDI) (for infants, toddlers, and preschoolers) and the Wyoming Department of Education Outreach Services for Deaf/Hard of Hearing (for school-age children). These two agencies assist families/schools/developmental preschools in the facilitation of educational needs for children with hearing loss.

Hearing aids are required to be fit using best practice recommendations from the Joint Committee on Infant Hearing (JCIH)[1] and/or the American Academy of Audiology (AAA)[1] Clinical Practice Guidelines for Pediatric Amplification which requires probe microphone verification technology (e.g., Verifit) ASK YOUR AUDIOLOGIST IF S/HE CAN PROVIDE PROBE MICROPHONE VERIFICATION or contact *Wyoming Families for Hands & Voices* for assistance in locating this required audiology service.

REQUIREMENTS TO INITIATE THIS APPLICATION:

1. **Pre-Approval Form – page 4**
2. **Audiometric data from the audiologist**
3. **Parental Commitment Contract – page 5**
4. **Consent for Release/Exchange of Information –page 6**
5. **Audiologist's Commitment Contract – page 7**

Submit these materials at the same time --
Application must be complete before processing

When *Wyoming Families for Hands & Voices* receives the **complete** application it will be reviewed and the parent and audiologist will be notified by email regarding the approval or non-approval of the application. Once the hearing aid(s) have been fit the audiologist must submit the **Audiologist's Request for Payment Form** and the required supporting documentation in order to receive payment.

PLEASE NOTE

- Recipients will not be considered for a consecutive set of hearing aids more than every four years.
- This Program is not for children whose hearing aids can be purchased by private insurance, Medicaid (Kid Care/CHIP), Children with Special Healthcare Needs, Department of Vocational Rehabilitation (DVR) or other available sources.
- WYCHAP funds cannot be used to meet insurance deductibles.
- A two-year single loss/damage warranty will be included with the hearing aids. Upon expiration of the initial warranty, the family will be responsible for purchasing further warranties. Families will also be responsible for purchasing future hearing aids and/or warranties if warranty is breached (i.e., hearing aids lost or damaged more than once).
- It is requested that hearing aids purchased for infants prior to cochlear implantation be returned to the WYCHAP program once the child is implanted.

Thank you for your interest in this program. If you have further questions please contact:

Wyoming Families for Hands & Voices
Wendy Hewitt
(307) 780-6476
wendy@wyhandsandvoices.org

Mail or fax all required forms and documentation to:
Wyoming Families for Hands & Voices
P.O. Box 1033
Mountain View, WY 82939
Fax: 307-333-0546

[1]www.jcih.org
[2]www.audiology.org

Wyoming Children's Hearing Aid Program (WYCHAP)

Dear Audiologist,

The WYCHAP is a fund that was established in 2012 by the Wyoming Legislature. The goal of WYCHAP is to provide timely access to hearing aids (fit using best practice recommendations) for children, ages birth through the end of their high school career, identified with hearing loss who are either not insured or under-insured. The funds are limited, distributed on a first-come first-serve basis, and availability of funding is dependent upon future legislative action**. Please review "Factors to Consider Before Applying for WYCHAP Funding" on page 9 with the parents before filling out the application.**

PLEASE NOTE:
Hearing aids are required to be fit using best practice recommendations from the Joint Committee on Infant Hearing (JCIH)[1] and/or the American Academy of Audiology (AAA)[1] Clinical Practice Guidelines for Pediatric Amplification which requires probe microphone verification technology (e.g., Verifit). If you do not have this technology available, *Wyoming Families for Hands & Voices* will assist the family in locating this service.

All hearing aids fit on WYCHAP participants (with the exception of infants who will be receiving cochlear implants) are required to accept DAI personal FM receivers. Bluetooth is not an acceptable substitute.

Parents are primarily responsible for ensuring that the application materials are submitted in a timely fashion. Please provide parents with audiometric data required in the Pre-Approval Form in order to expedite the application process.

The dispensing audiologist will be reimbursed for:

- The hearing aid manufacturer's invoiced amount, not to exceed $2000 per hearing aid with the inclusion of a two- year single loss/damage warranty for each hearing aid.
- $550 total for the fitting of the hearing aid(s).
- The cost of an initial set of ear molds, not to exceed $100 per mold.
  Parents/guardians or other payers cannot be invoiced for cost not covered by WYCHAP reimbursement.

PRE-APPROVAL REQUIREMENTS FROM THE AUDIOLOGIST:.

- All audiometric data/information
  - **For infants/toddlers/preschoolers:** (OAE/ABR/ASSR/BOA/VRA/Conditioned Play, Immittance with AR; statement regarding otoscopic inspection. Results must be within the last twelve months
  - **For school-age children:** (A/C and B/C thresholds, SRTs, WRS (phones/insert phones), Immittance with AR; statement regarding otoscopic inspection. Results must be within the last twelve months

When *Wyoming Families for Hands & Voices* receives the **complete** application it will be reviewed and the parent and audiologist will be notified by email regarding the approval or non-approval of the application . Once the hearing aid(s) have been fit the audiologist must submit the **Audiologist's Request for Payment Form** and required supporting documents in order to receive payment.

If you have questions about this program please contact:
Wendy Hewitt
(307) 780-6476
wendy@wyhandsandvoices.org

[1]www.jcih.org
[2]www.audiology.org

WYCHAP Pre-Approval Form

PARENT INFORMATION

Name of Child Receiving Hearing Aid(s): _____ Birth Date: _____

Parent or Guardian of Child: _____

Mailing Address: _____

_____

Primary Contact Name: _____

Home Phone Number: _____ Cell: _____

Secondary Contact Name: _____

Home Phone Number: _____ Cell: _____

Email Address:_____

Insurance Company: _____

Please describe your child's hearing loss (how much loss; what kind of hearing loss – ex: mild to moderate sensorineural hearing loss, bilaterally)_____

_____

HEARING HISTORY

Child's age when hearing loss was identified_____

Does your child currently wear a hearing aid(s)? _____ Yes _____ No If yes:

- Right Ear: Current Make/Model_____
  Age of hearing aid (years) _____
  Is current aid FM compatible: _____ Yes _____ No
- Left Ear: CurrentMake/Model_____
  Age of hearing aid (years) _____
  Is current hearing aid FM compatible: _____ Yes _____ No

If current hearing aid(s) is less than 3 years old and is FM compatible, please explain why you are requesting new hearing aid(s)_____

_____

EDUCATION/INTERVENTION

If your child attends public school, what is the name of the school district?_____

If your child attends a Child Development Center, what is the name of the Center?_____

_____

Does your child have an IFSP ___Yes ___No; an IEP ___Yes ___No, or 504 Plan ___Yes ___No?

AUDIOLOGIST INFORMATION

Name of Audiologist: _____

Audiologist's License Number: _____

Mailing Address: _____

_____

Office Phone Number: _____ Other Phone: _____

Fax Number: _____

E-mail Address: _____

Does the audiologist use probe microphone verification technology (e.g., Verifit)? _____Yes _____No

Wyoming Children's Hearing Aid Program (WYCHAP)
Parental/Guardian Commitment Contract

Child's Name:_____Child's DOB:_____

*By **initialing** in the space provided you are agreeing to each statement.*

_____ 1. I agree to return the hearing aids(s) to the Wyoming Children's Hearing Aid Program when/if my child receives a cochlear implant(s).

_____ 2. I certify that my child is not eligible to receive medical coverage for hearing aids through private insurance, Medicaid (Kid Care/CHIP), Children with Special Healthcare Needs, Department of Vocational Rehabilitation (DVR) or other such assistance programs which pay for hearing aids.

_____ 3. Hearing aids are not a covered expense or are a minimally covered expense under my insurance company.

_____ 4. I understand that the hearing aids will have a two-year single loss/damage warranty. I am responsible for any future warranties and/or the purchase of new hearing aids if such warranty is breached (i.e. hearing aid(s) are lost or damaged more than once).

_____ 5. My child will be seen by a licensed audiologist who will use best practice hearing aid fitting recommendations as put forth by the Joint Committee on Infant Hearing and/or the American Academy of Audiology Clinical Practice Guidelines for Pediatric Amplification which requires the use of probe microphone verification technology (e.g., Verifit).

_____ 6. I understand that payment for the initial set of ear molds will be covered under the Wyoming Children's Hearing Aid Program and that I am responsible for purchasing all subsequent ear molds as well as post-fitting audiological follow-up.

_____7. I understand that audiometric data, hearing history, and educational history information from this application will be shared with the Early Hearing Detection and Intervention (EHDI) program (for infants, toddlers, and preschoolers) **OR** with the Wyoming Department of Education Outreach Services for Deaf and Hard of Hearing (for school-age children).

My signature indicates that I agree with the above terms of the Wyoming Children's Hearing Aid Program.

Parent/Guardian Signature: _____

Date:_____

Wyoming Children's Hearing Aid Program (WYCHAP)
Consent for Exchange/Release of Information Form

Child's Name: _____ Date of Birth: _____

*By **initialing** in the space provided you are agreeing to the release/exchange of information among the following agencies.*

FOR SCHOOL-AGE CHILDREN

_____ Initial

Wyoming Department of Education

Outreach Services for Deaf/Hard of Hearing

Phone: (307) 777-6376

Email: janine.cole@wyo.gov

AND

_____ Initial

Child's School_____ _____

Address_____

_____

Phone_____

Email_____

FOR INFANTS, TODDLERS, PRESCHOOL CHILDREN

_____ Initial

Early Hearing Detection and Intervention (EHDI)

1771 Centennial Drive

Laramie, WY 82070

Phone: (307) 721-6212

Email: nancy.pajak@wyo.gov

AND

_____ Initial

Local Child Development Center_____

_____

Address_____

_____

Phone_____

Email_____

FOR ALL APPLICANTS

_____ Initial

Wyoming Families for Hands & Voices

P.O. Box 1033

Mountain View, WY 82939

Phone: (307) 780-6476 Fax: (307)333-0546

Email: wendy@wyhandsandvoices.org

AND

_____ Initial

Audiologist_____

Address_____

_____

Phone_____

Email_____

Reminder: This form must be included with the pre-approval application materials.

As the parent/guardian of the above-named child, I hereby authorize the exchange and release of information contained in this application among the parties identified above.

Parent/Guardian Signature: _____ **Date:** _____

Wyoming Children's Hearing Aid Program (WYCHAP)

Audiologist's Commitment Contract

Child's Name:_____Child's DOB:_____

*By **initialing** in the space provided you are agreeing to each statement.*

_____1. I agree to fit hearing aids on WYCHAP recipients using best practice recommendations from the Joint Committee on Infant Hearing (JCIH) and/or the American Academy of Audiology (AAA) Clinical Practice Guidelines for Pediatric Amplification which requires probe microphone verification technology (e.g., Verifit).

_____2. I agree that all hearing aids fit on WYCHAP participants (with the exception of infants who will be receiving cochlear implants) are required to accept DAI personal FM receivers. Bluetooth is not an acceptable substitute.

_____3. For school-age children I agree to provide a written report which includes functional audiometric data (aided SRT, aided SF WRS in quiet and in noise, aided responses to NBN or WPT) and comments regarding the impact/benefit of the hearing aid(s).

_____4. I agree to provide equipment generated verification (strip chart) indicating that probe microphone technology (e.g., Verifit) was utilized.

_____5. I have acquired medical clearance or waiver for this child to use amplification devices.

_____6. I have contacted the insurance company and I verify that the above child's insurance:

_____ Does not cover the cost of hearing aids

_____ Covers the cost of hearing aids up to $_____ per hearing aid

_____7. As the dispensing audiologist I understand I will be reimbursed for:

- The hearing aid manufacturer's invoiced amount, not to exceed $2000 per hearing aid with the inclusion of a two- year single loss/damage warranty for each hearing aid.
- $550 total for the fitting of the hearing aid(s).
- The cost of an initial set of ear molds, not to exceed $100 per mold.

_____8. As the dispensing audiologist I understand that parents/guardians or other payers cannot be invoiced for costs not covered by WYCHAP reimbursement. (e.g. Dispensing audiologists understand they are to dispense hearing aids at WYCHAP reimbursement rates and will not invoice parents, or other payers for additional funds.)

My signature indicates that I will comply with the above terms of the Wyoming Children's Hearing Aid Program.

Audiologist's signature:_____

Date:_____

I am recommending: ____monaural fitting; ____binaural fitting

Make/model of hearing aid(s) being recommended for this child_____

_____

Wyoming Children's Hearing Aid Program (WYCHAP)
Audiologist's Request for Payment Form

Name of Audiologist: _____
Audiologist's License Number: _____
Mailing Address: _____
_____
Office Phone Number: _____ Other Phone: _____
Fax Number: _____
E-mail Address: _____

Name of Child Receiving Hearing Aids: _____ Birth Date: _____
Parent or Guardian of Child: _____

Hearing Aid Manufacturer: _____
Hearing Aid Model: _____
Serial Number Right Aid: _____ Left Aid: _____
Two-year single loss/damage warranty expiration date: Right Aid: _____ Left Aid:_____

REQUIRED DOCUMENTS TO BE INCLUDED WITH THIS FORM

1. **An invoice created by you for the fitting fee, not to exceed a total of $550.**
2. **An invoice created by you for the cost of an initial set of ear molds, not to exceed $100 per mold.**
3. **A copy of the original manufacturer's hearing aid invoiced amount, not to exceed $2000 per hearing aid with the inclusion of a two-year single loss/damage warranty for each hearing aid.**
4. **Equipment generated verification (strip chart) that probe microphone technology (e.g., Verifit) was utilized.**
5. **For school-age children a written report which includes:**
    a. **Functional data (aided SRT, aided SF WRS in quiet and in noise, aided responses to NBN or WPT).**
    b. **Comments regarding impact/benefits of hearing aid(s).**

Audiologist's Signature_____**Date**_____

Mail or fax this form and all required documentation to:

Wyoming Families for Hands & Voices
P.O. Box 1033
Mountain View, WY 82939
Fax: 307-333-0546

Upon receipt of <u>all</u> completed documents listed above, the audiologist will receive payment within 30 days.

Factors to Consider Before Applying for WYCHAP Funding

A child's current hearing aids must be at least 4 years old to be considered for funding.

The WYCHAP funds are designated for children with educationally significant hearing loss. Educationally significant hearing loss is defined as follows:

- A bilateral hearing loss of at least 20 dB PTA in the better ear
- A unilateral hearing loss of at least 35 dB PTA in the affected ear
- A bilateral high-frequency hearing loss averaging at least 35 dB PTA at any two frequencies for 2000 Hz, 4000 Hz, or 6000 Hz
- A fluctuating conductive hearing loss that meets one of the above criteria for at least 3 months (cumulative) during the school year or 4 months annually

(DeConde Johnson, C, Benson, P, & Seaton, J. (1997) *Educational Audiology Handbook.)*

WYCHAP funds cannot be allotted to purchase equipment/devices to address Auditory Processing Disorder.

WYCHAP funds are used to purchase traditional hearing aids. Funds are not available for non-traditional fittings (deep canal hearing aids, personal amplifiers with flat generic responses or tinnitus maskers) Accessories such as FM receivers, FM transmitters, CROS transmitters, streaming devices, and microphones are also excluded.

WYCHAP funds can be used for a bone conduction hearing device, (ie. softbands) when a traditional hearing aid fitting is not feasible. Audiologists will be reimbursed for one devise. Reimbursement will be up to, but will not exceed $ 4000.00 for one. Funds may not be used for implantable devices. (ie.BAHA)