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. Applications will be processed on a first-come first-serve basis; however, in the event that funds become limited, applications may be prioritized based on a child's needs. The 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 by a licensed audiologist, 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**
6. **Health Insurance Worksheet (if applicant has coverage) – page 10**

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

Once Wyoming Families for Hands & Voices receives the complete application it will be reviewed. Following the review, 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 five 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.
- Applicants with health insurance that covers a partial amount of a hearing device are required to complete page 10. These applications will be reviewed and handled on a case by case basis. Deductibles, coinsurance, etc. will be taken into consideration. Note: Review of these applications may take longer.
- At least a two-year warranty covering a single loss/damage and any repairs of the hearing aids must be included. 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 strongly recommended that once the loss/damage warranty expires or is no longer in effect the family purchases their own hearing aid insurance.
- 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 any further questions, please contact:

Wyoming Families for Hands & Voices
Wendy Hewitt
(307) 780-6476
wychap@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–*Our fax is HIPPA secure and simplifies the application process*

[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.

It is strongly encouraged that hearing aids fit on WYCHAP participants (with the exception of infants who will be receiving cochlear implants) be compatible with hearing assistive devices (i.e. FM, ROGER technology)

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 at least a two-year warranty covering a single loss/damage and any repairs of the hearing aids, and not to exceed $4000 for a bone conduction device.
- $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, STR/Word Recognition (when child is developmentally able to perform the task), 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 completed 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 or wychap@wyhandsandvoices.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: _____ Phone Number: _____

Secondary Contact Name: _____Phone Number: _____

Email Address:_____

Insurance Company: _____

Wyoming Medicaid Coverage: _____ Yes _____ No

Please describe your child's hearing loss (degree of 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) _____
- Left Ear: CurrentMake/Model_____
  Age of hearing aid (years) _____

If current hearing aid(s) is less than 5 years old or still functioning, please explain why you are requesting new hearing aid(s)/new technology_____

_____

_____

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

[1]www.jcih.org

[2]www.audiology.org

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 WYCHAP **will not** cover aids more than every five years and that the hearing aids will have at least a two-year warranty covering a single loss/damage and any repairs of the aids. 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). I understand that it is recommended that I purchase hearing aid insurance when the warranty is no longer in effect.

_____ 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 appointments.

_____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.* ***Failure to consent could result in denial.***

FOR SCHOOL-AGE CHILDREN

_____ Initial

Wyoming Department of Education

Outreach Services for Deaf/Hard of Hearing

Phone: (307) 777-6376

AND

_____ Initial

Child's School/District_____

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

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

wychap@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 understand that fitting WYCHAP participants with hearing aids that are compatible with hearing assistive devices (i.e. FM, ROGER technology) is strongly encouraged.

_____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 or bone conduction device.

_____ Covers the cost of hearing aids up to $_____ per hearing aid or bone conduction device.

_____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 at least a two-year warranty covering a single loss/damage and any repairs for each hearing aid, and not to exceed $4000 for a bone conduction device.
- $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.)**

_____9. I understand that Payment Request Forms and other supporting documentation must be submitted to WYCHAP within **six months of the fitting date** or I could forfeit payment. Unless prior arrangements have been made.

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: _____
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. **The hearing aid manufacturer's invoiced amount, not to exceed $2000 <u>per hearing aid</u> with the inclusion of at least a two-year warranty covering a single loss/damage and any repairs for each hearing aid, and not to exceed $4000 for a bone conduction device.**
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 –*Our fax is HIPPA secure and simplifies the application process*

Upon receipt of <u>all</u> completed documents listed above, the audiologist will receive payment within 45 days.

Factors to Consider Before Applying for WYCHAP Funding

*A child's current hearing aids must be at least 5 years old to be considered for funding.

*If an applicant is approved, the initial set of hearing aids will come with at least a two-year warranty covering a single loss/damage and any repairs. Once this warranty expires or is no longer in effect, it is highly recommended to purchase an additional loss and damage warranty. There are several options for purchasing this insurance. Your Audiologist or WYCHAP can help you when looking for additional insurance.

*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/ROGER receivers, FM/ROGER 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 device. Reimbursement will be up to but will not exceed $4000.00 for one. Audiologists will be reimbursed the manufacturer's invoice price and a $550 fitting fee. Funds may not be used for implantable devices. (ie. Bone conduction device surgery)

Health Insurance Worksheet

This page <u>must</u> be filled out if the applicant has private health insurance coverage.

Date_____

Applicant Name_____ DOB_____

Insurance Company_____

Hearing Aid Coverage– Yes_____ No_____

In Network – Yes_____ No_____

Effective Date _____

Deductible – Individual _____/Amount Met_____
Family _____/Amount Met_____

Coinsurance_____

Out of Pocket Maximum- Individual _____/Amount Met_____
Family _____/Amount Met_____

Pre-certification Required- Yes_____ No_____

As the parent/guardian of the above-named child, I hereby authorize the exchange and release of Health Insurance information contained in this form among Wyoming Families for Hands & Voices, and Audiologist Office. I verify that the information on this form is correct. I also understate that an Insurance Explanation of Benefits form could also be required prior to payment.

Parent/Guardian Signature _____Date_____

As the fitting Audiologist of the above-named child, I verify that the information on this form is correct. I also understate that an Insurance Explanation of Benefits form could also be required prior to payment.

Audiologist Signature _____Date_____