

Kansas Hearing Aid Loan Bank Application Form

Today's Date: _____
Child's Name: _____ Child's Date of Birth: _____
Parent/Guardian Name: _____ Phone Number: _____
Current Address: _____ City: _____ Zip Code: _____
EMAIL Address: _____
Alternate Contact Name: _____ Phone Number: _____
Primary Language Spoken in Home: _____ Family size: _____ State where child was born: _____
Age he/she was identified with hearing loss: _____ Name of Health Insurance: _____
Does child currently have a hearing aid? Yes / No If yes, please explain: _____

Parents/Guardian:

By signing below you affirm that the information contained in this application is current and complete. ***If approved*** for a hearing aid through the Kansas Hearing Aid Loan Bank you understand that ear molds are not part of this loaner program; the hearing aid(s) provided remain the property of the Kansas Hearing Aid Loan Bank and you agree to: take care of the hearing aids; keep your appointments with your audiologist; return the hearing aids at the end of 6 months from the initial fitting. Additionally, you understand that Sound Beginnings will collect data from this application to track information about the Loaner Bank and the Newborn Hearing Screening Program and specific information about your child and his/her hearing loss may be shared with early intervention professionals or agencies.

Parents/Guardian Signature: _____ Date: _____

Audiologist Use Only

As a participant in the Kansas Hearing Aid Loan Bank I agree to adhere to all laws regarding hearing aid fitting in the State of Kansas. I attest that hearing aid selection is based on age appropriate evaluation procedures and that appropriate fitting verification procedures are followed and the patient receiving the hearing aid is between the age of 0-36 months.

Dispensing Audiologist: _____ Phone: _____

Fax: _____ Email: _____

Address: _____

Audiologist Signature: _____ Date: _____

Hearing Aid(s) Requested: _____ Widex Mind M-19 _____ Phonak Naida V UP
_____ Widex Mind M-9 _____ Phonak Nios III _____ BAHA BP100
_____ Widex Baby 440

_____ Monaural _____ Binaural **FAX completed form to: Kansas Infant Hearing Aid Loan Bank**
Attention: Dr. Sprecher, CCC-A, FAAA
Doctor of Audiology
913.324.0601

Loan Bank Use Only:

Date received _____ Date shipped _____ **Date due back to KSD** _____

Make _____ Model _____

SN# _____ SN# _____ Date returned _____