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Cincinnati Children's
changing the outcome together

CCHAT

Cincinnati Children's Hearing Aid Trust

CCHMC Hearing Aid Request Form

Audiologist's Name: _____
Practice Street Address: _____
City/St/Zip: _____ County: _____
Phone: _____ Fax: _____

Have you taken a patient through CCHAT before? ☐Yes ☐If not, please submit a Provider Application.

Managing Physician's Name: _____

Parent/Guardian Information

Parent Name(s): _____ Email: _____
Parent Address: _____
City/State/Zip: _____ County: _____
Home #: _____ Cell #: _____ Work #: _____ Fax #: _____

Patient Information

Patient Name: _____ Date of Birth: _____ *MRN#: _____

Hearing Loss

In which ear is a hearing device being requested: ☐Left ☐Right ☐Both
Does child have a PTA of at least 25dB in requested ear(s)? ☐Yes ☐No

Testing

Please include a copy of the current audiogram taken within 6 months, physiologic test results, physician visit forms and any other pertinent audiological information needed for diagnosis with this request.
Anything else we should know?
_____
_____

Hearing Aids

We provide hearing aids from Oticon and Phonak. All aids also come with a Patient Care Kit. Contact CCHAT Coordinator for updated offerings.
Please select your model preference:

Oticon Ship to Account #: _____

OPN PLAY 2 ☐BTE PP
XCEED PLAY 2 ☐SP ☐UP
PLAY PX 2 ☐MINIBTE R ☐MINIBTE T

Phonak Ship to Account # : _____

NAIDA P50 ☐UP
SKY M50 ☐ M ☐PR ☐SP

Color: _____

Contact information to where hearing aid(s) should be delivered:

Name: _____

Address: ☐ Same practice as above; if not: _____

By printing your name below, you affirm that the information contained within this application is current and complete. If a change in any information occurs, please notify CCHAT immediately. Additionally, I grant permission to the Cincinnati Children's Hearing Aid Trust to release all medical records pertaining to my patient's hearing disorders to the assigned CCHAT Coordinator for the purposes of applying for alternative financial assistance.

Audiologist Signature: _____ Print: _____ Date: _____

******After completing form entirely, please attach document in e-mail and send to: Kelly.Brockman@cchmc.org. If you have any questions please contact: Kelly Brockman at 513-636-CHAT (2428). Form can also be faxed to: 513-636-8133 ATTN: Kelly Brockman or mailed to: Cincinnati Children's Hospital Medical Center, ATTN: Kelly Brockman, 3333 Burnet Avenue, MLC 2018, Cincinnati, OH 45229-3039.******

The Cincinnati Children's Hearing Aid Trust reserves the right to change the eligibility criteria at any time without written notification. The program will provide funding for hearing aid amplification as long as the funds for the program are available.

Updated: 3/2023