3333 Burnet Avenue • MLC 2018 • Cincinnati, OH • 45229
513-636-CHAT (2428) • www.cincinnatichildrens.org/cchat

CCHAT

Cincinnati Children's Hearing Aid Trust

APPLICATION FOR ASSISTANCE
TO BE COMPLETED BY PARENTS OR GUARDIAN

Requirements: Ohio Resident, Birth to Age Three, Requesting first hearing aid(s)

Name of Child: ______________________ Date of Birth: ____________ SS#: _______________________

Parent/Guardian Name:

Mother: ______________________ Father: _____________________ Guardian: ____________________

Address: ____

City: ________________________ Zip Code: __________ County of Residence: ____________

Preferred Phone #: _________________________ Backup Phone #: _____________________

****Email**: ______________________________________

Ethnicity: ☐ Hispanic or Latino ☐ Not Hispanic or Latino ☐ Prefer not to answer

Race: ☐ American Indian or Alaskan Native ☐ Asian ☐ Black or African American
☐ Native Hawaiian or other Pacific Islands ☐ White ☐ Other ☐ Prefer not to answer

1) When was your child first diagnosed with a hearing loss? Give approximate dates. _______________
2) Was your child screened for hearing loss when he/she was born at the hospital? ☐ Yes ☐ N
3) Did your child pass the newborn hearing screening? ☐ Yes ☐ No
4) What hospital was your child born? ____
5) Who referred you to the CCHAT Program? ____
6) Has your child ever worn hearing aids? ☐ Yes ☐ No
   a. If yes, please explain: ____
7) Are you currently receiving services from an early intervention program for your child (speech therapy, Help Me Grow)? ☐ Yes ☐ No
8) Are you currently receiving services from the Regional Infant Hearing Program of Ohio? ☐ Yes ☐ No
   a. If no, may we refer your name to the program? ☐ Yes ☐ No

Upon approval of this application from CCHAT, we agree to the following:

a) To be fiscally responsible for the maintenance, daily care, batteries, repairs, ear molds and replacement of my child's hearing aids in the future.
b) To return the hearing aids purchased by CCHAT to CCHAT if my child no longer needs the hearing aids. The hearing aids will be used as loaners for other children.
c) To notify CCHAT Coordinator immediately if a change in any information occurs and/or you receive any additional funding through private insurance or any other third party funding assistance program.

Signature of Parent/Guardian: ______________________________ 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: 03/2019