



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
Has child been fit with amplification on a trial basis? 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, Phonak, and Widex. All aids also come with a Patient Care Kit. Contact CCHAT Coordinator for updated offerings.

Please select your model preference:

Oticon Ship to Account #: _____

SENSEI: 312 13 SP
SENSEI PRO: 312 13 SP
OPN 3 13PP
OPN PLAY 2 BTE PP

Phonak Ship to Account # : _____

NAIDA B50 SP UP
SKY B50 M P SP UP
SKY V50 M P SP UP
SKY M50 M PR

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.