Center for Deaf and Hard of Hearing Education

haapi hearing aid assistance program of indiana
administered by hear INDIANA

Indiana Department of Health

AUDIOLOGIST REGISTRATION

Revised 7/1/2021

Note: Each audiologist who is interested in participating in HAAPI must complete a separate registration form, even if another audiologist within the same facility has already done so.

AUDIOLOGIST INFORMATION

Audiologist Name _____

Email _____ Indiana License Number _____

Facility Name _____

Address _____

Phone Number _____ Email Address _____

PROGRAMMING INFORMATION

Which of the following do you have the software to program?

Traditional Hearing Aids

☐ Oticon ☐ Phonak ☐ Resound ☐ Other _____

Bone Anchored Hearing Aids

☐ Oticon Medical ☐ Cochlear

BILLING INFORMATION

Billing Contact Name _____

Email _____

Phone Number _____

Address for Mailing Payments _____

_____

_____

REQUIRED DOCUMENTS

☐ By initialing here I indicate understanding that my registration will not be accepted until the following documentation has been received:

☐ Valid Indiana License ☐ Proof of Professional Liability Coverage ☐ W-9

As a HAAPI Participating Audiologist, I agree to the following:

• I hold a current Indiana licensure in audiology, and will maintain an unrestricted Indiana license at all times while participating in HAAPI.

• I currently have and will maintain professional liability insurance at all times while participating in HAAPI. I understand that all clinical decisions regarding hearing aids and all professional services are my responsibility, and that neither HAAPI nor the HAAPI administrators have any healthcare provider relationship with my patients.

• I understand that my Participating Audiologist Registration Forms must be accepted prior to submitting my first hearing aid order through HAAPI.

• I will assist the family with applying to HAAPI. I understand that the family's application must be approved prior to ordering a hearing aid through HAAPI on behalf of a family. I will complete my due dilligence to investigate other possible sources of funding before completing the application for HAAPI.

• I understand that the family must submit an audiogram completed within six months and a medical clearance signed by a Medical Doctor (MD) or Doctor of Osteopathy (DO) licensed in Indiana and dated within six months of the date the application is received.

• I have reviewed the American Academy of Audiology (AAA) and the American Speech-Language-Hearing Association (ASHA) clinical practice guidelines on pediatric amplification and agree to abide by the audiological best practices listed therein. (A copy of these guidelines is available at HAAPIndiana.org/AAAguidelines.)

• I will select the most appropriate FM compatible hearing aid from the approved list taking fitting range into account.

• I understand that HAAPI will provide hearing aid(s), which include a 3-year warranty, an earmold or softband, and a pediatric care kit that I agree to pass along to the patient at time of fitting.

• I understand that HAAPI will pay a fitting fee of $400 for one ear or $600 for two ears and I agree not to charge the patient for the fitting If I accept the fee from HAAPI.

• I understand that HAAPI will pay a follow-up fee of $250 for one ear or $350 for two ears and I agree to work with the family to schedule annual follow-up appointments at least one year post fitting and one year from one another.

• I will submit the invoice to HAAPI administration within 60 days of fitting and 60 days of follow-up.

• I understand that I will not make a profit on the aids/molds obtained through this program by collecting deductibles, insurance payments, or balance billing the family for services provided.

• I understand that the follow-up appointments are only covered once every 365 days. If an appointment is needed before then, I will clearly explain my usual and customary rates (if applicable) to the family before scheduling.

• I agree to return aids to the manufacturer (crediting the HAAPI account) if the aid is not dispensed or if it is returned for some reason.

• I will work with recipient's family in an attempt to return original devices to HAAPI administrators.

Authorized Signature Date

Email, scan, fax, or mail this application and supporting documents to:

Hear Indiana
ATTN: HAAPI
4740 Kingsway Dr Ste 33
Indianapolis, IN 46205

info@HAAPindiana.org
Fax: 888-887-0932
Questions? Call 317-828-0211