SPEECH & HEARING CLINIC
UNIVERSITY of WASHINGTON

Welcome to UW's Hearing Aid Assistance Program (HAAP)!

HAAP assists adults on a low income to obtain appropriate hearing healthcare. Patients are fit with refurbished, behind-the-ear hearing aids which have been donated to our program. Services are provided by graduate student clinicians under the supervision of our faculty, who are licensed audiologists.

This letter is to inform you about our new and improved HAAP application process because you indicated your interest in receiving low-cost hearing aids. Due to clinic staffing and capacity, we can schedule up to two HAAP patients per month.

Attached to this letter is an application for HAAP services. If you are still interested in this program, please complete this application and send it back to UW Speech and Hearing Clinic (address listed below). Please also include a copy of your most recent audiogram, if available. After receiving your materials, we will contact you to schedule an appointment based on the order in which your application was received.

Depending on your hearing loss the cost can range from **$250 for one hearing aid to $550 for a pair**. If you decide to move forward with HAAP following your hearing aid consultation appointment, we will require a $100 deposit at that time. We will collect the remaining balance for your hearing aids at your fitting appointment.

Thank you for your application; we appreciate your patience throughout this process.

Sincerely,
UW HAAP Audiology Team

If you have any questions, please contact:

UW Speech and Hearing Clinic
ATTN: HAAP
4131 15th Ave NE
Seattle WA 98105

Phone: 206-543-5440
Email: shclinic@uw.edu
Fax: 206-616-1185

UNIVERSITY of WASHINGTON
Department of Speech & Hearing Sciences

UW HEARING AID ASSISTANCE PROGRAM (HAAP) APPLICATION FORM

Last Name	First Name
Street Address	**City, State, Zip**
Primary Phone	**Secondary Phone**
Email Address	***Please put a * by your preferred method of contact: Phone, email, mail.***

Date of Birth:		**Age**		**Gender**	**Preferred Pronouns**
Referred by:					

Do you need an interpreter? **If yes, which language:**

Please send a copy of your most recent audiogram (hearing test) with this application:

Date of hearing test:		**Location:**	

If you have obtained medical clearance for amplification, indicate physician name/date

Physician:		**Date of evaluation:**	

Do you have health insurance? If so indicate below:	**No**	**Yes**

☐ **Medicaid/WA Apple Health Coverage** ☐ **Employer Group Plan**
☐ **Medicare** ☐ **Other**

☐ **I attest that my household income does not exceed:**

$41,000 for a 1-person household*
$55,000 for a 2-person household*
$70,000 for a 3-person household*
*Please call to inquire about income limits for larger households.

I understand that the UW HAAP will use this information solely for the determination of HAAP eligibility.
I agree that the information submitted above is true and accurate.

_____ _____

Signature Date

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RELEASE OF CONFIDENTIAL INFORMATION

Client Name: _____ Date of Birth: _____

The University of Washington Speech & Hearing Clinic is hereby given permission to send summaries of the speech-language and/or hearing evaluations, treatment notes, and/or treatment progress summaries to the individuals listed below. Additionally, I give my permission for the following agencies and/or professionals to release medical/educational information to the University of Washington Speech & Hearing Clinic. I understand that the information will be treated in a confidential manner per this agreement.

Please enter names, addresses, and fax numbers. Check if we are to send information to, or receive information from, each person listed.

Send to ☐ Receive from* ☐

Name:_____ Fax: _____

City: _____ State: _____ Zip Code: _____

Send to ☐ Receive from* ☐

Name:_____ Fax: _____

City: _____ State: _____ Zip Code: _____

Send to ☐ Receive from* ☐

Name:_____ Fax: _____

City: _____ State: _____ Zip Code: _____

Send to ☐ Receive from* ☐

Name:_____ Fax: _____

City: _____ State: _____ Zip Code: _____

*Please provide records for time period of ____ / ____ / ____ through ____ / ____ / ____.

_____ _____

Signature of Client or Person Responsible for Care **Date of Signature**

Consent for release of medical records/confidential information is valid for ninety (90) days from the date of signature.

UW Speech & Hearing Clinic
4131 15th Ave NE
Seattle, Washington 98105-6246

Ph – 206.543.5440 Fax – 206.616.1185
shclinic@uw.edu
https://sphsc.washington.edu/clinic