SPEECH & HEARING SCIENCES
UNIVERSITY of WASHINGTON

UW Hearing Aid Assistance Program (HAAP) Application Form

DESCRIPTION OF SERVICES/APPLICATION REQUIREMENTS

The UW HAAP assists adults with a qualified low income to obtain appropriate hearing healthcare. **The UW HAAP requires that a patient have current Medicaid/WA Apple Health coverage as the criteria for eligibility for this program**. Patients are fit with refurbished behind-the-ear hearing aids which have been donated to the UW HAAP.

To apply, please complete and provide:

1. UW HAAP Application Form (see attached)
2. Copy of Proof of current Medicaid/WA Apple Health coverage
3. Copy of your most recent hearing test
4. Release of Information Form (see attached)

Mail the above items to the address below:

UW Hearing Aid Assistance Program
UW Speech and Hearing Clinic
4131 15th Ave NE
Seattle, WA 98105

You will be contacted by our clinic to let you know if you qualify for the HAAP. Once approved, you will be placed on our waiting list. We will contact you to schedule a consultation when an opening becomes available at the UW Speech and Hearing Clinic.

HAAP Costs to Patient:

- Non-refundable application fee $150 (collected at consult appt)
- HA and Fitting Fee:
  - Monaural fitting $150
  - Binaural fitting $250
- Earmolds, if applicable at $60 per ear

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Questions regarding the UW HAAP should be directed to the UW HAAP office at 206-685-4267. The office is staffed part-time. Therefore, if you do not reach a staff member please leave a detailed message and your call will be returned as soon as possible.

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**	
Referred by:					
Do you need an interpreter?	**If yes, which language:**				
Hearing History: Date and location of your last hearing evaluation; please send a copy of your audiogram with this application.					
Date:		**Location:**			
If you have obtained medical clearance for amplification, indicate physician name/date					
Physician:		**Date of evaluation:**			
Do you have Medicaid/WA Apple Health Coverage?			**No**	**Yes**	
Please submit a copy of the front and back of your medical card. This information is essential to verify your coverage.					

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