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

Consent for Care and Clinic Policies Agreement Form

Please read each section of this form and initial that you have read and understand each policy. Then provide a signature at the end of this form confirming that you have read and understand each section.

CONSENT FOR CARE

I hereby authorize the UW Speech and Hearing Clinic to provide evaluation and treatment services for the above-named client. Additionally, if the faculty, staff, and/or other clinic personnel determine that the client is in need of emergency medical care, the clinic is hereby authorized to obtain the care required, at the expense of the undersigned.

I have read and understand the Consent for Care statement: _____ (initials)

NOTICE OF INFORMATION PRACTICES & PRIVACY POLICY

We keep a record of the health care services we provide you. You may ask to see and copy that record. You may also ask us to correct that record. We will not disclose your record to others unless you direct us to do so or unless the law authorizes or compels us to do so. You may see your record or get more information about it, as well as obtain a copy of the complete Notice of Information Practices and Privacy Policy by calling 206-543-5440.

I have read and understand the Notice of Information Practices & Privacy Policy: _____ (initials)

SUPERVISION OF MINORS POLICY

Under state law, individuals under the age of 18 are considered minors. Parents/guardians are asked not to leave the clinic while a minor under the age of fourteen is in therapy at this clinic. For clients ages 14 to 17, parents/guardians may choose whether or not to accompany the minor to their appointment. Parents/guardians are solely responsible for determining how their children may safely travel to the UW Speech & Hearing Clinic for their appointment (e.g. bus, drive, walk, bike, etc).

I have read and understand the Supervision of Minors Policy: _____ **(initials)**

MOBILITY TRANSFERS AND RESTROOM POLICY

Clinicians, faculty and staff are not allowed to assist with transfers and toileting. A caregiver or family member of the individual receiving services must be present when the client needs physical assistance with transferring from wheelchair to chair, during ambulation in the clinic, or for bathroom assistance.

I have read and understand the Mobility Transfers and Restroom Procedures Policy: _____ **(initials)**

DISABILITY ACCOMMODATIONS

Both front and back entrances to our clinic are accessible. Both entries have automatic openers, as do our restrooms. Please let us know if you need any accommodations to facilitate receiving services from our clinic.

Accommodations needed:

OBSERVATION AND RECORDING POLICY

The services offered to individuals seen in the Clinic are part of the University's education program. University of Washington faculty, staff, and students receive educational benefits from observing diagnostic, treatment, and other services offered in the University facilities.

Basic Consent: I understand that by accepting services from the Clinic I consent to observation by UW faculty, staff, and students, either live, via recording, or via closed circuit television when I (or the client) receive services.

I understand that I (or the client) may be observed: _____ **(initials)**

Full Consent: In addition, I give my consent to the UW Speech and Hearing Clinic to make audio and/or video recordings of me (or the client) while receiving services to be used for educational purposes, provided the name of the client or other personal identification information is not revealed. These data are only available for educational training purposes. All uses for commercial or research purposes are prohibited unless a separate permission is obtained. Segments of the digital recording with accompanying transcriptions may be presented in the context of academic symposia, university classes, and professional, family or client training activities.

I give my consent to be recorded for educational purposes: _____ **(initials)**

CONSENT TO BE CONTACTED FOR RESEARCH POLICY

UW Speech & Hearing Sciences and the UW Speech & Hearing Clinic are committed to advancing clinical research to improve the lives of people living with communication disorders. Please initial below if you are interested in being contacted by faculty in this department about research studies for which you might be an appropriate participant. You can decline to participate even if you are contacted, you can rescind this offer at any time with no repercussions, your information will not be shared with anyone else on campus or in the community, and you will not be contacted unless you fit the criteria for a specific study.

I give my consent to be contacted about research: _____ **(initials)**

By signing this page, I acknowledge that I have read and agreed to the terms of this Consent for Care and Clinic Policy Agreement Form:

Name of Client: _____ **Date of Birth:** _____

_____ _____

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

If signed by someone other than client, state relationship to client: _____

Consent for Sharing of Digital Records via Email or Cloud Sharing

Please read each section of this form and initial that you have read and understand each policy. Then provide a signature at the end of this form confirming that you have read and understand each section.

CONSENT FOR SHARING OF DIGITAL RECORDS

I hereby authorize the UW Speech and Hearing Clinic to share digital copies of documents, audio recordings, and/or video recordings via email, cloud sharing (such as Dropbox, Google Drive, OneDrive, etc.), or other methods that may be available.

I have read and understand the Consent for Sharing of Digital Records statement: _____ (initials)

NOTICE OF CONFIDENTIALITY RISK

Sharing of digital records via email, cloud sharing (such as Dropbox, Google Drive, OneDrive, etc.), or other methods that may be available may not be secure. The UW Speech and Hearing Clinic cannot guarantee the security and confidentiality of your records that are shared in this manner.

I have read and understand the Notice of Information Practices & Privacy Policy: _____ (initials)

By signing this page, I acknowledge that I have read and agreed to the terms of this Consent for Sharing of Digital Records via Email or Cloud Sharing.

_____ _____

Printed Name of Client **Date of Birth**

_____ _____

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

If signed by someone other than client, state relationship to client: _____

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4131 15th Ave NE
Seattle, Washington 98105-6246

206.543.5440
shclinic@uw.edu
https://sphsc.washington.edu/clinic

SPEECH & HEARING CLINIC
UNIVERSITY of WASHINGTON

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 provide the organization name, ATTN to, address, and fax number for each entry. Check the box to indicate whether we can send information to and/or receive information from each organization below.

Send to ☐ Receive from* ☐

Organization:_____ Fax: _____

ATTN: _____ City: _____ State: _____ Zip Code: _____

Send to ☐ Receive from* ☐

Organization:_____ Fax: _____

ATTN:_____ City: _____ State: _____ Zip Code: _____

Send to ☐ Receive from* ☐

Organization:_____ Fax: _____

ATTN: _____ City: _____ State: _____ Zip Code: _____

Send to ☐ Receive from* ☐

Organization: _____ Fax: _____

ATTN: _____ 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 365 days from the date of signature.

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