South Dakota Hearing Aid Assistance Program
Application Form

South Dakota Department of Human Services, Division of Rehabilitation Services

Personal Information

Name: _____ Date of Birth: _____

Parent(s) Name: _____ SS#: _____

Street Address: _____ City/St/Zip: _____

County of Residence: _____ Email Address: _____

Home/ Cell Phone Number: _____ Work Number: _____

Has applicant ever worn hearing aid(s)? Yes ☐ No ☐

If yes, did applicant receive hearing aid(s) from this program or SD Medicaid? Yes ☐ No ☐

If yes, when were these hearing aid(s) received? Date: _____

Eligibility

To be eligible for the Hearing Aid Assistance Program, the individual must meet the following criteria:

- The individual must be a resident of South Dakota;
- The individual must be under 19 years of age;
- The individual must have a progressive or permanent hearing loss which requires hearing aid(s);
- The individual must not have received a hearing aid(s) from this program or SD Medicaid within 3 years prior to the date of application; and
- The individual must be financially eligible.

Insurance Coverage

The Hearing Aid Assistance Program is the payer of last resort. An applicant must utilize any private health insurance as well as all other third party resources before being eligible for this program.

Is the applicant covered for hearing aid(s) under Medicaid or Health Insurance Plan? Yes ☐ No ☐

If yes

Name of Insurance: _____ Phone: _____

If insurance does not cover the entire cost of the hearing aid(s) and associated ear molds, the Hearing Aid Assistance Program will cover any remaining costs in accordance with the program rules and sliding fee scale. Please provide any relevant coverage information along with this application.

Income

List monthly income for all members within the current household. Complete the table below and identify each household member with income.

Accepted forms include:

1. Most recent federal tax form (1040 Tax Return) is preferred, or;
2. Income or wage statements (Examples include pay statements, social security, unemployment, public assistance, or other statements verifying money received by the family). Include at least three consecutive ones with this application. *Note: If one or more family members are currently employed in seasonal employment, last year's tax return is required rather than monthly income.

South Dakota Hearing Aid Assistance Program Sliding Fee Scale

Total Number of Members in Household:_____

Type of Income	Annual Amount
Gross wages	
Self-Employment	
Social Security, SSI or SSDI	
Pensions	
Public Assistance	
Unemployment/ Worker's Compensation	
TOTAL	

2019 Federal Poverty Guidelines			
Family Size	**200%**	**300%**	**400%**
1	$24,980	$37,470	$49,960
2	$33,820	$50,730	$67,640
3	$42,660	$63,990	$85,320
4	$51,500	$77,250	$103,000
5	$60,340	$90,510	$120,680
6	$69,180	$103,770	$138,360
7	$78,020	$117,030	$156,040
8	$86,860	$130,290	$173,720
More than 8- add the below figure for each additional person			
	$ 8,840	$ 13,260	$ 17,680
% of Poverty Level	=<200%	201% - 300%	301% - 400%
% of financial contribution provided by Program			
	100%	75%	50%

Upon approval of this application, I agree to the following:

a) To be responsible for the daily care, maintenance, batteries, and replacement ear mold(s).
b) To accept the terms of payment for any audiological services not covered by the program (fitting/dispensing, replacement ear mold(s), follow-up visits).
c) Make payment directly to the audiologist for any applicable balance not covered by the financial contribution provided by the program.

I affirm that the information provided is complete and correct to the best of my knowledge.

Signature of Parent/Guardian:_____ Date: _____

Or if the applicant is at least 18 years of age

Signature of Applicant:_____ Date: _____

Please return this form via mail, fax or email to:

Katie Gran
Division of Rehabilitation Services
811 E 10th St Dept 21
Sioux Falls SD, 57103
Fax – (605) 367-5327
Katie.Gran@state.sd.us

To determine eligibility, the Division of Rehabilitation Services must receive the following information:

- A completed application form.
- Verification of household gross income.
- A Medical Clearance, Evaluation and Prescription form completed by the audiologist.
- Any applicable insurance coverage.

If you have any questions, please contact Katie Gran at 605-367-4657 or Katie.Gran@state.sd.us

Revised 01/2019