

**EARLY INTERVENTION
HEARING SERVICE GUIDELINES**



**Illinois Department of Human Services
Division of Community Health and Prevention
Bureau of Early Intervention**



**Hearing and Vision Early Intervention Outreach
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Bureau of Early Intervention**

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HEARING SERVICE GUIDELINES

INTRODUCTION

The purpose of the Hearing Service Guidelines is to assist Child and Family Connections (CFC) staff with the procedural operations of the statewide Early Intervention Services System as it relates to infants and toddlers with hearing loss. All Child and Family Connections procedures apply and are not necessarily repeated here unless it is specific to hearing.

Training for all Service Coordinators called Serving Families of Children With Hearing Loss is available through the on-line Service Coordinator Training and as a stand alone module through Illinois EI Training at www.illinoiseitraining.org. Additional in-depth training is available for Designated Service Coordinators through Hearing and Vision Early Intervention Outreach (HV/EIO).

These guidelines and reference materials are also used as supporting documents for other trainings conducted by HV/EIO and are available on line at www.morgan.k12.il.us/isd/hvc.

HEARING SERVICE GUIDELINES

SECTION I: GENERAL INFORMATION

HEARING LOSS

Children who are deaf or hard of hearing and their families should have access to Early Intervention services from the earliest age possible. These children and their families benefit from intervention to assist them in understanding the unique needs a hearing loss presents on language, communication, socialization, and overall development.

Each year it is estimated about 360 children are born in Illinois with hearing loss. The ages of birth through three are critical for children who have hearing loss because this is the age when children are acquiring language and developing communication skills which ultimately impact future academic achievement. Special attention must be given to receptive and expressive communication to ensure that these children will reach their full potential.

Recent studies have shown that infants with hearing loss can be acquiring language similar to peers by five years of age if they are identified and provided with appropriate early intervention services before six months of age by providers trained in service delivery for children who are deaf or hard of hearing. Even a six month delay, identification at twelve months of age, causes significant reduction in the rate of language acquisition.

DEAF-BLINDNESS/ DUAL SENSORY LOSS

A child with both a vision and hearing loss faces a unique view of the world. When a child has such a dual sensory loss, they are considered deaf-blind. Deaf-blindness is often misunderstood, because sometimes people think a child has to be TOTALLY deaf and TOTALLY blind to qualify. This is not true, as it is the combination of vision and hearing loss that is considered deaf-blindness. Many children considered deaf-blind have enough vision to be able to move about in their environment and recognize people, see sign language at close distances and even perhaps read large print. Other children have enough hearing to recognize familiar sounds, understand some speech and/or develop speech themselves. For a child who can see and hear, the world extends as far as his/her eyes and ears can reach. A child who is deaf-blind has a world that is initially much narrower. When a child is profoundly deaf and totally blind, his/her experience of the world extends only as far as the fingertips can reach.

Collaborative services from other agencies, such as Philip Rock Center/Project Reach, are available to help the child achieve his/her outcomes and should be listed in his/her IFSP, with the funding source appropriately identified.

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HEARING AND VISION EARLY INTERVENTION OUTREACH

Hearing and Vision Early Intervention Outreach (HV/EIO) is the statewide Early Intervention training, resource, referral and technical assistance program for infants and toddlers who have a vision loss, hearing loss, or dual sensory loss. The program's goal is for all children in Illinois who are deaf, hard of hearing or visually impaired to have appropriate Early Intervention services. HV/EIO provides free online newsletters and collaborates with other agencies for the provision of annual parent conferences throughout the state. HV/EIO offers training on a variety of topics related to hearing. A number of informational resources are available through HV/EIO's website at www.morgan.k12.il.us/isd/hvc.

PHILIP ROCK CENTER – PROJECT REACH

Project Reach is supported by a federal grant to provide technical assistance, information and training that addresses the early intervention needs of children with deaf-blindness. Project Reach's deaf-blind specialists can be one of the services and supports that are identified in a child's IFSP to help with achieving identified outcomes. Technical assistance is provided through in-service training and in home/ on site consultation to families and service providers. Services are provided in collaboration with any early intervention provider. There is no charge for Project Reach services.

Project Reach serves children and youth, aged birth – 21 who have a combined vision and hearing challenge. This expanse of age range of service allows Project Reach to be an integral part of transition teams, and can help children and families move from early intervention to educational services. A referral should be made to determine if a child is eligible for this program's services. Referrals can be made to the Project Reach- Illinois Deaf-Blind Program at (630) 790-2474 Voice, (800) 771-1232 TTY, or prc@project-reach.org.

ILLINOIS SERVICE RESOURCE CENTER

Illinois Service Resource Center (ISRC) is supported by a federal grant through the Illinois State Board of Education as a Technical Assistance Center to provide services to address the behavior needs of children with hearing loss. ISRC team members can be one of the services and supports that are identified in a child's IFSP to help with achieving identified outcomes. Technical assistance is provided through in-service training and in home/ on site consultation to families and service providers. Psychological testing, a variety of resources, and a 24 hour helpline are also available. Services are provided in collaboration with any early intervention provider. There is no charge for ISRC services.

ISRC serves children and youth, aged birth – 21 who have combined hearing and behavior challenges. This expanse of age range of service allows ISRC to be an integral part of transition teams, and can help children and families move from early intervention to educational services. A referral should be made to determine if a child is eligible for this program's services. Referrals can be made to ISRC at (847) 559-8195 V/TTY, or isrc@isrc.us.

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DESIGNATED SERVICE COORDINATORS

Each Child and Family Connections office has a designated service coordinator(s) for families of children with hearing loss. These service coordinators participate in detailed training, provided by HV/EIO, specific to service delivery for children with hearing loss.

The Bureau of Early Intervention and Hearing and Vision Early Intervention Outreach have a list available of current designated service coordinators. Changes in designated service coordinator contact information are reported by the CFC to the Bureau and HVEIO who revise and disseminate the list at least semi-annually.

SPECIALIZED PROVIDERS

Developmental Therapists/Hearing

A credentialed Developmental Therapist/Hearing (DTH) is an educator with a degree in Special Education/Deaf and Hard of Hearing and receives authorizations under the service types Aural Rehabilitation and Developmental Therapy. As Aural Rehabilitation providers, DTHs address outcomes related to information on hearing loss, amplification options, literacy, language acquisition, and communication methodologies and modes. DTHs, speech therapists and audiologists can all be authorized to provide aural rehabilitation services although aural rehabilitation services are most often provided by a DTH.

Deaf Mentor

Deaf Mentors are adults with a hearing loss who are enrolled under Family Training and Support after completing training through HVC. They go into the home to provide support to the family while working closely with the provider of aural rehabilitation services and other team members. The Deaf Mentor shares personal experiences, models language in the family's chosen modes, introduces the family to the local deaf community, and shares information about Deaf Culture.

PARENT INFANT INSTITUTE

The Institute for Parents of Preschool Children Who Are Deaf or Hard of Hearing is a family learning experience designed to provide information and support to families so that they can make informed decisions on behalf of their child, under 5 years of age, who is deaf or hard of hearing. Parents participate in classes, lectures and workshops presented by experts from around the state while their child attends class supervised by experienced teachers of the deaf. Siblings ages 7 and under are also welcome to attend and are provided activities and childcare. Meals and on campus housing are provided free for the families. A variety of in depth evaluations are available with follow up recommendations. Registration for the Institute typically held in June, is through the local office of the Division of Specialized Care for Children (DSCC). Phone 1-800-322-3722. For more information about the Institute, visit the ISD website at www.morgan.k12.il.us/isd.

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SECTION II: POLICIES AND PROCEDURES

UNIVERSAL NEWBORN HEARING SCREENING

Illinois mandated the Hearing Screening for Newborns Act effective as of December 31, 2002, based on results of longitudinal studies which showed that children with hearing loss who were identified and received early intervention prior to six months of age had reduced permanent developmental delays compared to peers identified after six months of age. With this screening taking place in all Illinois birthing hospitals, more infants are being identified and referred to Child and Family Connections (CFC). Since the Illinois Department of Public Health (IDPH) is responsible for tracking all infants, most referrals will be faxed from IDPH. The Bureau of Early Intervention or HV/EIO may assist IDPH with locating the correct CFC and forwarding the referral, but in this case, IDPH is the official referral source. The CFC may also receive a referral from other sources such as the parent, hospital, pediatrician, audiologist or Division of Specialized Care for Children (DSCC).

For any family who has a child with an identified hearing loss, the CFC must complete the *CFC Consent for Release of Information/Children with Identified Hearing Loss* form and send it to IDPH to verify that the child has been connected to early intervention. This document also helps track how many children in Illinois have hearing loss. This form is in the CFC procedure manual and is an addendum to this document. As stated in the procedure manual, complete this form if the child meets any of the following criteria: 1) the child presented with an identified hearing loss during initial enrollment; 2) the child was referred from an IDPH Newborn Hearing Program with a confirmed hearing loss; 3) an identified hearing loss was confirmed after the initial IFSP meeting; or 4) the family of a child with an identified hearing loss chose not to accept EI services.

INTAKE

All contact with families referred to Early Intervention must be in the family's language and mode of communication. Interpreter services may be needed for a service coordinator to communicate with parents for IFSP meetings, as well as to conduct evaluations and provide direct services. When interpreter services for the deaf are linked directly to a specific child, these services can be authorized as part of that child's IFSP.

Interpreter services for the deaf may also be needed for a CFC to conduct its business, including holding provider meetings. The Americans with Disabilities Act ensures that interpreters be provided for equal access of information for individuals who are deaf or hard of hearing. The CFC should cover the cost of these services. There are different types of interpreters for the deaf such as ASL interpreters, Signed English or Cued Speech transliterators, and tactile sign interpreters for the deaf-blind. Very few of these interpreters are enrolled in the EI system. A list of enrolled interpreters for the deaf can be generated using the interpreter search function on the Provider Connections website by selecting the language "sign." The interpreter search function does not differentiate between the different types of interpreters for the deaf. Interpreters for the deaf have the provider type "ID" in the Cornerstone system. Service coordinators use this provider type when generating a family training and support authorization with an appropriate

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interpreter procedure code. If an enrolled interpreter for the deaf is not available, the provisional authorization process may be used, following the procedures provided in the Provider Selection and Provisional Authorization Process in the CFC Procedural Manual. A list, by county, of registered interpreters can be found on the Illinois Deaf and Hard of Hearing Commission website at www.idhhc.state.il.us.

For all families, a *Screening Device for Determining Family Fees and Eligibility for All Kids and DSCC* form is completed during Intake. When a child presents with a suspected or confirmed hearing loss, a referral to DSCC is indicated. On the *Screening Device*, hearing loss would be checked as a suspected or diagnosed medical condition that may potentially make the child DSCC eligible. A child has a suspected hearing loss when supported by concern from the parent or physician that the child does not respond normally to sound, (e.g. awareness, localization, discrimination, recognition, etc.) Children with eligible degree of hearing loss would be medically eligible for DSCC care coordination services, regardless of family income. Ongoing medical treatment for hearing loss is provided by DSCC based on financial need.

ELIGIBILITY DETERMINATION

Evaluation Authorizations

CFCs should ensure that evaluation is completed in all five developmental domain areas. The area of physical development includes vision and hearing. Screening results from Universal Newborn Hearing Screening can be considered for children under six months of age. Hearing loss can be progressive or be acquired after birth. If the child is older than six months and has not had a hearing screening within the last six months, an effort should be made to determine if that child needs a hearing screening/evaluation completed by an audiologist. HV/EIO has developed a functional screening tool for hearing that is helpful in identifying these children. Trainings by HV/EIO on using this tool are provided throughout the state. The tool is available on the HV/EIO website and as an addendum to this document. Any member of the evaluation team may complete this Functional Hearing Screening.

A *Screening Device for Determining Family Fees and Eligibility for All Kids and DSCC* form is completed and a referral made to DSCC, regardless of income or insurance, when:

- A child has a confirmed hearing loss
- A child has a suspected hearing loss supported by concern from the parent or physician that the child does not respond normally to sound, (e.g., awareness, localization, discrimination, recognition, etc.). If the child has no other DSCC medically eligible conditions, DSCC will arrange a diagnostic audiological evaluation at no cost to the family. This includes audiological evaluations requiring anesthesia, sedation, or medical monitoring. DSCC does require families to maximize third-party medical coverage, including All Kids.

Notes:

- DSCC does not cover screening/monitoring of hearing sensitivity. DSCC does cover diagnostic evaluations when a potentially eligible condition is suspected, but is undiagnosed, and the child has no medical eligible condition(s) already diagnosed that would be eligible.

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- Referrals to DSCC should not be based solely on delayed speech and language indicators.

Children with an eligible degree of hearing loss would be medically eligible for DSCC care coordination services, regardless of family income. If the child is DSCC eligible, ongoing support following diagnostics is provided by DSCC based on financial need.

The *Consent for Release of Information – Children With Identified Hearing Loss* form should be completed for children with an identified hearing loss 1) at the time of the initial IFSP meeting or 2) anytime after the initial IFSP meeting that an identified hearing loss is confirmed or 3) if the family of a child with an identified hearing loss chooses not to accept services from Early Intervention Service System. See the Addendum for this form.

As stated in the CFC Procedure Manual, “In order to maximize all available resources, evaluations conducted by providers within or outside of the EI Services System prior to referral can and should be used to assist in eligibility determination and IFSP development if they are current (within the last six months) and contain all needed information.” Reports from previous audiological evaluations should be considered, when appropriate. Service coordinators should generate an authorization for an audiological evaluation with a frequency of one time for the authorization when any of the following situations apply:

- child presents a possible hearing loss at referral;
- a possible hearing loss was identified via parent report during intake or at any other time during the Individualized Family Service Plan (IFSP) process;
- a child fails a functional hearing screening completed during evaluations to determine eligibility for EI;
- a member of the EI service team identifies a possible hearing loss after the IFSP was initially developed and direct services have begun;
- a child has failed the initial newborn hearing screening test and there has been no follow up to that failed test; or
- prior to the annual IFSP meeting if needed.

The authorization does not list procedure codes. Audiologists will bill using the list of procedure codes provided to them. This authorization process will ensure that all testing can be completed on the same date of service unless unforeseen circumstances prevent all testing from being completed on the same date. If such circumstances arise, the audiologist must request a second Audiological Evaluation authorization prior to completing further testing.

EI does not pay for medical testing that requires anesthesia, sedation or medical monitoring. A referral to DSCC for medical testing that requires anesthesia, sedation or medical monitoring is appropriate only when the child meets the criteria for referral, stated above. EI will not pay for the following types of evaluations and services:

- evaluations completed without a referral from the service coordinator;
- evaluations completed prior to the receipt of an EI authorization;
- ongoing evaluations to monitor a diagnosed hearing loss. This is a medical service that must be billed to and paid by resources other than EI;
- ongoing evaluation to monitor a fluctuating hearing loss. This is a medical service that must be billed to and paid by resources other than EI.
- evaluations to determine if a child is a candidate for a cochlear implant. A cochlear implant is a medical intervention; or

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- follow up visits to monitor cochlear implants. Follow up visits to monitor cochlear implants are medical services to monitor a medical intervention.

If the child does not present with a confirmed or suspected hearing loss, he/she should be referred to the primary care physician for follow-up. Audiologists have been asked to refer families back to the service coordinators to explain that EI does not pay for this type of testing prior to scheduling such testing.

Eligibility Criteria

A child can be determined eligible for EI based upon developmental delay, a diagnosed physical or mental condition that typically results in developmental delay or is at risk of substantial delay based upon defined criteria. The criteria for EI's identified medical condition related to hearing loss resulting in high probability of developmental delay took effect January 23, 2008 with implementation of the Amended EI Rule 500 Appendix E. It states:

“Hearing loss of 30 decibels (dB) or greater at any two of the following frequencies: 500, 1000, 2000, 4000, and 8000 Hertz (Hz) or hearing loss of 35 dB or greater at any one of the following frequencies: 500, 1000, and 2000 (Hz) involving one or both ears.”

INDIVIDUALIZED FAMILY SERVICE PLAN

Initial/Annual IFSP Development

Documentation of a confirmed hearing loss does not make a child eligible for Aural Rehabilitation services. An Aural Rehabilitation evaluation must be completed. The evaluation to determine eligibility or add a new service must be completed by a credentialed evaluator. It is important to note that the same individual cannot complete a global evaluation and an Aural Rehabilitation evaluation on the same child because developmental therapy and Aural Rehabilitation are two separate services that require two separate authorizations.

The DTH offers support to the IFSP team when developing strategies for outcomes related to parent education, language acquisition, communication skill development, social/emotional development, and amplification.

Deaf Mentors (DM), when possible, should also be considered for inclusion on the team at the point when a family has made decisions related to communication and language. It is important to match the appropriate DM with the family's chosen modes.

Provider Selection and Provisional Authorization Process

DTHs and DMs are extremely limited in many parts of the state. When the need for such a specialist is identified and no direct service provider is available, the provisional authorization process may be used, following the procedures provided in the Provider Selection and Provisional Authorization Process section of the CFC Procedure Manual. Service coordinators are encouraged to contact HV/EIO for assistance in locating a provider.

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HEARING AID ASSESSMENTS

EI service coordinators will generate authorizations for hearing aid assessments if the following situations apply:

- child presents with an established hearing loss and may need hearing aids;
- an audiological evaluation completed via an EI authorization has established a hearing loss and the child may need hearing aids.

EI service coordinators will not generate authorizations and EI will not pay for additional hearing aid assessments once the need for hearing aids has been determined and prior approval obtained from the appropriate payee (EI or Division of Specialized Care for Children). If it is determined that a child requires hearing aids and the appropriate payee is EI, EI service coordinators will generate authorizations for the hearing aid(s) and the dispensing fee. EI will not pay additional charges for freight, postage, delivery, instruction, fitting, adjustments, or measurement, as these services are considered to be “all inclusive” in a payee’s charge for the item or service requested. Additional charges cannot be billed to the family.

ASSISTIVE TECHNOLOGY AUTHORIZATIONS

HV/EIO, DHS and DSCC worked collaboratively to develop the document: Hearing Aids/Accessories in the Early Intervention System, which is an addendum to this document and can be located on the HV/EIO website www.morgan.k12.il.us/isd/hvc . Please refer to the procedures identified, when requesting this type of Assistive Technology. Early Intervention pays for hearing aids prior to All Kids and after Division of Specialized Care for Children (DSCC) or personal insurance has been maximized. If the child may be DSCC eligible, a referral to DSCC is made prior to requesting EI approval for Assistive Technology. If it is clear that the family will not be DSCC eligible according to available DSCC financial eligibility guidelines, the request for Early Intervention Assistive Technology may be submitted to prevent delay in obtaining hearing aids for a child.

TRANSITION

As with all children in Early Intervention, transition activities begin no later than six months prior to the child’s third birthday. Service Coordinators should ensure that the appropriate Local Education Agency is notified and involved in transition planning and activities. Many School Districts have an Educational Supervisor of Programs for HH/Deaf Individuals. These Supervisors can assist in coordinating appropriate services for school age children. For assistance in identifying the supervisor for a child’s area you may contact HV/EIO.

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FAMILY SUPPORT

Families of children who are deaf or hard of hearing face unique challenges. The vast majority of children who are deaf or hard of hearing are born to hearing parents. No two families require the same kinds of support and the child’s needs change over time. Each age presents new challenges.

Family support is as important as the child's intervention needs. Parents consistently report that their need for support was most significant during the time their child was first identified. Ongoing parent-to-parent dialogue is a highly desirable and effective support. Illinois has a Chapter of Families for Hands and Voices, a parent support network for families of children with hearing loss. Illinois Families for Hands and Voices also has the Guide By Your Side program which provides one on one parent support. For more information contact GBYS@Choicesforparents.org or 866.655.4588. There are many other resources available throughout the state which can provide support to parents. Early Intervention, in collaboration with DSCC and HV/EIO have compiled a Hearing Resource Packet which service coordinators provide to families of children with hearing loss and is available on line at www.morgan.k12.il.us/hvc. A parent manual was developed specifically for Illinois parents of infants and toddlers with hearing loss. Information on how to obtain a manual is included in the packet. HV/EIO has parent resources and Supporting Families booklets that are available at www.morgan.k12.il.us/isd/hvc. Check with the family's DTH and DM for additional supports.

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Additional parent support information and state specific information can be found at:

www.illinoisoundbeginnings.org

<http://www.eiclearinghouse.org>

Early Intervention funds cannot pay for all of the services that a child with a hearing loss may need, but it is important to consider and explore all needs and resources with the parents.

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**SECTION III: ADDENDUM
RESOURCES, TOOLS and FORMS**

Definitions Related to Hearing Loss

Functional Hearing Screening Tool and Instructions

CFC Consent For Release of Information/Children With An Identified Hearing Loss

Hearing Aids/Accessories in the Early Intervention System

DEFINITIONS RELATED TO HEARING LOSS

This document contains words or terms commonly used in the identification, evaluation, assessment, and service provision of children with hearing loss.

ACOUSTICS: The qualities of a room, hall, auditorium, etc., that determine how well sounds can be heard.

AIDED AUDITORY THRESHOLD: The softest intensity that an individual wearing amplification (e.g., hearing aid) can hear a sound.

AMERICAN SIGN LANGUAGE/ ASL: One of the 5000+ natural languages that exist in the world. It is primarily known by members of the Deaf community in the United States. ASL is a complex, abstract language like all spoken languages. It is produced in a visual-spatial mode and has its own phonology, syntax, and morphology. ASL uses hand shapes, positions, movements, facial expressions and body movements to convey meaning. ASL has a rich history of literature and culture. ASL is a manual language that is distinct from spoken English (not based on English grammar/syntax). English, or Spanish, etc., is taught as a second language.

AMERICANS WITH DISABILITIES ACT (ADA): Signed into law on July 26, 1990, the ADA prohibits discrimination on the basis of disability in employment, programs and services provided by state and local governments, goods and services provided by private companies, and in commercial facilities.

AMPLIFICATION: The process of increasing the power of a signal (sound). In audiological reports, this term may refer to hearing aids, cochlear implants, and assistive listening devices.

ASSISTIVE LISTENING DEVICE: Specially designed electronic equipment for use by individuals who are deaf or hard of hearing. It amplifies speech and other sounds using a microphone, transmitter and receiver and channels sound more directly to the person.

AUDIOGRAM: A graph on which the person's ability to hear is recorded. It shows the lowest intensity (loudness) at which the person responds to different frequencies (pitches).

AUDIOLOGIST: A person holding a masters or doctorate degree in audiology and who is licensed by the state of Illinois to provide audiological services.

AUDIOLOGY SERVICES: Services may include identification of children with auditory impairment, using at risk criteria and appropriate audiological screening techniques; determination of the range, nature and degree of hearing loss and communication functions by use of audiological evaluation procedures; referral for medical and other services necessary for the habilitation or rehabilitation of children with hearing loss; provision of auditory training, aural rehabilitation, speech reading and listening device orientation and training, and other services; provision of services for prevention of hearing loss; and determination of the child's need for individual amplification, including selecting, fitting, and dispensing appropriate listening and vibrotactile devices, and evaluating the effectiveness of those devices.

DEFINITIONS RELATED TO HEARING LOSS

AUDIOMETER: A calibrated electronic instrument for measuring hearing sensitivity.

AUDITORY AWARENESS: Detecting when a sound is present as demonstrated by a change in behavior that occurs in response to the sound.

AUDITORY BRAIN STEM RESPONSE/ ABR: Electrophysiological measurement of the brainstem's response to acoustic stimulation of the ear. This test is both a screening and diagnostic tool. This test is often used with children because it can provide information about hearing levels in each ear without requiring a behavioral response. The test is performed while the child is sleeping (natural or sedated sleep depending on the age of the child). Other acronyms for this test are BAER, BEAR, and BSER.

This test involves placing measuring electrodes on the child's head and recording brain wave activity when sounds are presented. The loudness level of the stimulus is varied in order to determine the softest level at which the auditory nerve and brainstem are responding to sound. With diagnostic ABR, threshold is obtained in each ear. Since ABR is sensitive to auditory and neurological status, the absence of a response by ABR does not necessarily indicate an absence of usable hearing. Amplification and further behavioral audiological evaluations are necessary to determine how much usable hearing a child has.

AUTOMATED AUDITORY BRAINSTEM RESPONSE/AABR: An objective electrophysiological measurement of the brainstem's response to acoustic stimulation of the ear, obtained with equipment which automatically provides a pass/refer outcome. This test is a screening tool provided in some hospitals in Illinois. The equipment has software which analyzes the infant's response and compares it to normative data.

AUDITORY-AURAL: Method that teaches a child to make maximum use of his/her remaining hearing through amplification (hearing aids, cochlear implant, FM system). This method also stresses the use of speech reading to aid the child's communication. Use of any form of manual communication (sign language) is not encouraged although natural gestures may be supported.

AUDITORY DISCRIMINATION: Ability to perceive differences in unlike sounds which may affect a person's ability to understand speech and environmental sounds.

AUDITORY NEUROPATHY: A term presently used to describe a condition, found in some individuals, in which the patient exhibits auditory characteristics consistent with normal peripheral function but abnormal neural function. The combined use of otoacoustic emissions (OAEs) with ABR is essential to make this diagnosis. Note: Hyperbilirubinemia is a high risk factor for auditory neuropathy.

AUDITORY SKILL DEVELOPMENT (auditory training): The use of special techniques and equipment to assist children who are deaf or hard of hearing with the identification and understanding of sound.

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AUDITORY VERBAL PHILOSOPHY: Emphasizes the earliest use of the most appropriate type of high-tech amplification to facilitate the acquisition and use of spoken language. This philosophy uses methods which focus on developing the ability to listen and communicate with spoken language. This philosophy teaches a child to develop listening skills through one-on-one therapy that focuses attention on use of remaining hearing (with the aid of amplification). Since this method strives to make the most of a child's listening abilities, no manual communication is used and the child is discouraged from relying on visual cues.

AURAL (RE) HABILITATION: Specialized services for children who are deaf or hard of hearing which helps them develop language and communication skills including speech reading, listening and speaking.

BABBLING: Using consonant-vowel syllable repetitions in self-initiated vocal play, e.g., "ma-ma-ma".

BEHAVIORAL GAIN: The difference between aided and unaided thresholds as determined by audiological tests.

BEHAVIORAL OBSERVATION AUDIOMETRY: This testing is performed in a sound treated booth. An infant's detection or awareness of speech and warble tones or narrow band noise is obtained in the soundfield and/or under earphones. Behavioral responses such as quieting, cessation of sucking, eye blink, eye widening and startling, are observed.

BILATERAL HEARING LOSS: A hearing loss in both ears.

BONE CONDUCTION HEARING AID: A hearing aid in which the amplified signal directly stimulates the inner ear via a bone vibrator placed on the mastoid bone behind the ear. This type of hearing aid is typically used for individuals with atresia or chronic ear drainage.

COCHLEAR IMPLANT: An auditory prosthesis that uses electrical current to directly stimulate the auditory system which the brain interprets as sound. It does not restore normal hearing. It is intended for the auditory and speech habilitation or rehabilitation of individuals who are deaf. The implant consists of a surgically placed internal receiver and an externally worn microphone, signal processor, and transmitter.

COOING: sounds an infant produces as he/she exhales that are usually vowel-like and can sound like gurgling.

CONDITIONED PLAY AUDIOMETRY: This test can be performed by a trained tester or an audiologist. Responses to speech or tones are obtained in each ear under ear phones. The child responds by performing an action, such as placing a block in a bucket or raising a finger or hand when he or she hears the tone.

DEFINITIONS RELATED TO HEARING LOSS

CONDUCTIVE HEARING LOSS: An interference with the transfer of sound through the external and/or middle ear on its way to the inner ear. This loss may be caused by middle ear fluid, ear infection, structural malformation, foreign objects, etc. A conductive hearing loss may be corrected and/or improved with medical and/or surgical treatment. Some conductive hearing loss may be permanent.

CONGENITAL HEARING LOSS: Hearing loss that is present from birth. It may or may not be inherited.

CUED SPEECH: A visual communication system of eight handshapes (cues) that represent different sounds of speech. These cues are used while talking to make the spoken language clearer through vision. This system allows the child to distinguish sounds that look the same on the lips.

DEAF: A hearing loss so severe or profound that the individual experiences difficulty in processing speech through hearing, with or without amplification.

DEAF MENTOR (also Language Mentor for the Deaf): Deaf Mentors are adults with a hearing loss who are enrolled under Family Training and Support after completing training through HVC. They go into the home to provide support to the family while working closely with the provider of aural rehabilitation services and other team members. The Deaf Mentor shares personal experiences, models language in the family's chosen modes, introduces the family to the local deaf community, and shares information about Deaf Culture.

DECIBEL (dB): A measurement of sound intensity (loudness). The larger the number, the louder the sound.

DESIGNATED SERVICE COORDINATOR: Each Child and Family Connections office has designated service coordinators for families of children with hearing loss. These service coordinators participate in detailed training, provided by HVC, specific to service delivery for children with hearing loss.

DEVELOPMENTAL THERAPIST / HEARING (DT/H): A Developmental Therapist/Hearing (DTH) is an educator with a degree in Special Education/Deaf and Hard of Hearing and is credentialed to provide service under Aural Rehabilitation as a DTH and under Developmental Therapy as a DT. These providers address outcomes related to information on hearing loss, amplification options, literacy, language acquisition, and communication methodologies and modes. DTHs, speech therapists and audiologists can all be authorized to provide aural rehabilitation services although aural rehabilitation services are most often provided by a DTH.

DIAGNOSTIC AUDIOLOGICAL EVALUATION: the physiologic and behavioral procedures required to evaluate and diagnose hearing status.

DEFINITIONS RELATED TO HEARING LOSS

DIVISION OF SPECIALIZED CARE FOR CHILDREN / DSCC: University of Illinois at Chicago, Division of Specialized Care for Children is the Title V program in Illinois designated to assist eligible children with special health care needs, and their families. DSCC provides care coordination, information provision, and referral for any children with eligible medical conditions. DSCC also provides financial assistance for families who are financially eligible. Hearing loss and certain eye impairments are two of the eligible conditions included in the DSCC program. DSCC can help families obtain hearing aids, cochlear implants, ENT (Ear Nose Throat) care, medications, educational services and other community resources which may be beneficial to families. Regional Office information can be obtained from their website at <http://www.uic.edu/hsc/dscc>.

E.N.T.: An abbreviation used to refer to a physician (M.D.) whose practice is limited to disorders of the ears, nose and throat. E.N.T. is often used to refer to physicians practicing otology, otolaryngology or otorhinolaryngology. An ENT addresses the health and structure of the ear.

ENVIRONMENTAL SOUNDS: Sounds that occur in the person's surroundings. Usually does not include speech.

EVOKED OTOACOUSTIC EMISSIONS (OAE): This is a test that measures how well a child's cochlea, or inner ear works. This test is performed by an audiologist or a trained technician. It is used to screen infants at birth at some hospitals in Illinois. A soft rubber ear piece is placed in the baby's outer ear and makes a soft clicking sound. Healthy ears will "echo" the click sound back to a microphone inside the ear piece that is in the baby's ear. This test provides an objective measure of cochlear function. It does not assess neurological status. It is affected by fluid in the middle ear or debris in the ear canal. It is not a test of hearing per se but a test of cochlear function.

EXPRESSIVE LANGUAGE: Communication conveyed by spoken language, written language, sign language, fingerspelling and natural gestures. True expressive language is spontaneous, not imitated.

FEEDBACK: In hearing aids, feedback is "whistling or howling". This is created when the amplified sound from the hearing aid escapes from the ear canal through ear mold vents or slit leaks and is picked up by the microphone of the same hearing aid.

FINGERSPELLING: Spelling words using the manual alphabet.

FREQUENCY: The number of sound vibrations per second, also known as pitch, most commonly written as Hz (Hertz). For example, the frequency of 1000 sound vibrations per second is written as 1000 Hz (the greater the number, the higher the pitch).

FUNCTIONAL GAIN: The difference (in dB) between aided and unaided responses to sound.

GAIN: The amount that a hearing aid amplifies sound. Gain is expressed in decibels.

DEFINITIONS RELATED TO HEARING LOSS

HARD OF HEARING: A hearing loss which falls in the mild to moderately severe range and may prevent development of full awareness of environmental sounds and spoken language, with or without a hearing aid. Normal language acquisition and learning achievement may be limited.

HEARING: Commonly defined as the perception of sound. One of the five senses of the body.

HEARING AGE: The number of months/years a child has worn amplification, and has demonstrated usable hearing in the speech range.

HEARING AID: A wearable instrument which amplifies sound intended to help a person with a hearing loss. Usually consisting of a microphone, amplifier and earphone, and powered by a low voltage battery. Hearing aids can be worn behind the ear, in the ear, and sometimes on the body. Hearing aids do not restore normal hearing, but can improve the wearer's ability to hear.

HEARING AND VISION EARLY INTERVENTION/ HV/EIO: A statewide Early Intervention training, resource, referral and technical assistance program for infants and toddlers who are deaf, hard of hearing, or visually impaired

HERTZ (HZ); When testing hearing, Hz is used to indicate the frequency of a sound or pitch. The lower the number, the lower the pitch. The higher the number, the higher the pitch. A 250 Hz sound is a very low pitch, and an 8000 Hz sound is a very high pitch.

ILLINOIS DEPARTMENT OF PUBLIC HEALTH/IDPH: State agency charged, through Hearing Screening for Newborns Act, with collecting information about each child with a positive hearing screening result and maintaining a registry of cases of positive hearing screening results, including information needed for the purpose of follow-up services.
Website: www.idph.state.il.us.

INTENSITY: The loudness of a sound, measured in decibels (dB). The larger the number, the louder the sound.

INTERPRETER: A specially trained and certified individual who facilitates communication between two languages. A sign language interpreter is licensed by the state of Illinois and either signs a spoken message to an individual who is deaf or hard of hearing or speaks a signed message. In Early Intervention, sign language interpreters are enrolled under the provider type interpreter for the deaf (ID) but not credentialed. Procedures are available for enrollment through the Early Intervention system for individuals who are sign language interpreters.

LOCALIZATION: Turning in the direction of or locating the sound source. Children with a unilateral hearing loss may have difficulty localizing sound.

MANUAL COMMUNICATION: Includes any form of manually coded English (MCE), American Sign Language (ASL), or a combination of ASL and MCE.

MILD HEARING LOSS: A hearing loss between 20 dB and 40 dB. Children with a mild loss may have difficulty hearing faint or distant speech. This may be especially so in a noisy situation. May benefit from a hearing aid.

DEFINITIONS RELATED TO HEARING LOSS

MODERATE HEARING LOSS: Hearing loss between 41 dB and 55 dB. Children with a moderate loss may have difficulty understanding speech in most settings and may require a hearing aid and specialized EI services from an appropriate provider. Children with this degree of hearing loss automatically qualify for Illinois Early Intervention services.

MODERATELY SEVERE HEARING LOSS: Hearing loss between 56 dB and 70 dB. With hearing aids, speech may not be understood even if the sound is loud. Requires a hearing aid to help understand speech and specialized EI services from an appropriate provider. Children with this degree of hearing loss automatically qualify for Illinois Early Intervention services.

MONAURAL: Refers to only one ear.

NORMAL HEARING: Thresholds of hearing at 20 dB or less

ORALISM: A communication method which uses speech, speech reading, and listening with appropriate amplification.

OTITIS MEDIA: Inflammation or infection of the middle ear.

OTOLOGIST: A physician, (M.D.) whose practice is limited to the treatment of disorders of the ear. Also see E.N.T.

OTOLARYNGOLOGIST: A physician, (M.D.) whose practice is limited to the treatment of disorders of the ear and throat. Also see E.N.T.

OTORHINOLARYNGOLOGIST: A physician, (M.D.) whose practice is limited to treatment of disorders of the ears, nose and throat. Also see E.N.T.

PRESSURE EQUALIZING TUBES / PE TUBES: Tiny plastic tubes that are inserted in the eardrum. They are sometimes used to treat chronic otitis media. Also known as ventilation tubes.

PROFOUND HEARING LOSS: A hearing loss of 91dB or greater. Amplification, specialized services by an Early Intervention appropriate provider, and communication systems are often necessary. Children with this degree of hearing loss automatically qualify for Early Intervention.

PURE TONE: A single frequency sound without accompanying overtones or other sounds.

PURE TONE TESTING: Hearing testing done to establish an individual's threshold (lowest level) of hearing at individual frequencies.

REAL EAR TESTING: A test which measures how much amplified sound from a hearing aid is being transmitted at the child's eardrum.

RECEPTIVE LANGUAGE: Communication received through spoken language, written language, sign language, finger spelling and natural gestures.

DEFINITIONS RELATED TO HEARING LOSS

RESIDUAL HEARING: The amount of unaided, usable hearing.

SCREENING: The completion of one or more objective, physiologic, electronic tests administered to determine the need for further diagnostic testing by an audiologist and physician. Such screening shall be performed by individuals who have been appropriately trained in the procedure and instrumentation used.

SENSORINEURAL HEARING LOSS: An interference with the transfer of sound located in the inner ear and/or the auditory nerve. This type of hearing loss is permanent. The individual with this type of hearing loss may benefit from amplification.

SEVERE HEARING LOSS: A hearing loss between 71dB and 90dB. May require amplification and specialized Early Intervention services from an appropriate provider. Children with this degree of hearing loss automatically qualify for Early Intervention services.

SIGNED ENGLISH: Sign language and gestures are used to code English lexical items, morphology, syntax, and semantics.

SOUND FIELD SYSTEM: An amplification system that can be used in places where background noise and distance from the speaker might hinder a child's ability to hear.

SPEECH DISCRIMINATION: Ability to differentiate speech sounds.

SPEECH RANGE: The frequencies between 500 and 2000 Hz. Most of the energy contained in human speech is in this frequency range. The frequencies usually tested are 250, 500, 1000, 2000, 4000, and 8000 Hz.

SPEECHREADING: The process by which a person follows a conversation by watching a speaker's lip movements, understanding the context of the situation, and by predicting what is being said by the topic of the conversation. Also called lip reading.

SPEECH RECOGNITION THRESHOLD / SRT: The lowest level, in decibels, at which a person can detect and understand speech 50% of the time. The speech reception threshold is the softest level at which a person is able to understand two syllable words.

THRESHOLD OF HEARING: The lowest intensity (quietest level) at which a person can hear a sound 50% of the time.

TOTAL COMMUNICATION/ TC: A philosophy which encompasses every mode of communication. Focuses on using the family's preferred modes of communication. It can include oral, auditory, speech reading, sign language, writing and/or gestures. This philosophy quickly became synonymous with the simultaneous method (i.e., the use of signing and speaking in English at the same time) although total communication is much more than signing and speaking at the same time.

TRANSLITERATION: The process of changing one form of an English message, either spoken English or signed English, into the other form.

DEFINITIONS RELATED TO HEARING LOSS

TYMPANOMETRY: This test is used to determine how well the middle ear is functioning, for example, if there is fluid present, by showing how the middle ear system changes with variations of pressure in the external ear canal. This is not a test of hearing sensitivity.

UNIVERSAL NEWBORN HEARING SCREENING / UNHS: Screening of all newborns in the birthing hospital for potential hearing loss. UNHS provides objective measures which identify children who may be at risk for hearing loss. In Illinois, UNHS is a joint effort between the Department of Public Health, Department of Human Services, and Division of Specialized Care for Children.

UNILATERAL HEARING LOSS: A hearing loss occurring in one ear. A child with this hearing loss does not automatically qualify for Illinois Early Intervention services unless they also demonstrate an additional medical diagnosis of developmental delay or are determined eligible through clinical opinion.

VISUAL REINFORCED AUDIOMETRY: Behavioral, head turning responses for speech (speech awareness) and warble tones from 250 to 8000 Hz performed by an audiologist in a sound treated booth or under head phones. There are loud speakers on either side of the child and light and motion activated toys which are used as reinforcement after the child has turned his or her head toward the loud speaker in response to a sound. Responses are obtained for speech (“Hello- look here”) and tones. VRA combines auditory and visual (generally animated, lighted toy) stimulation to eventually elicit a conditioned response to auditory stimulation in the absence of visual stimulation. Visual reinforcement is then provided following response to auditory stimulus.

VOCALIZATION: Sounds which a child produces either spontaneously or through imitation.

Functional Hearing Screening Tool & Instructions

Child's Name _____ Today's Date _____

INSTRUCTIONS

This tool was developed using the National Institute on Deafness and Other Communication Disorders' "Your Child's Hearing Development Checklist." Training on the use of this tool is available from Hearing and Vision Connections (HVC) and can be requested at www.morgan.k12.il.us/isd/hvc. When referring a child for follow-up hearing screening or diagnostic assessment, multiple factors should be considered. The items listed in the tool allow for collaboration with the parent and the medical home. When parental concern or medical and/or social history suggests a concern regarding hearing, follow-up is needed.

Authorize an audiological examination for children enrolled in Early Intervention if upon completion of SECTION ONE Functional Hearing Screening:

- BRIEF HEALTH HISTORY includes one or more "Yes" response(s) For items that involve the number colds, allergies and ear infections, the child's primary care physician should concur with the need for an audiological examination prior to authorization.
- DEVELOPMENT BY PARENT REPORT includes one or more "No" response(s) OR if a child in the age range 10-36 months does not appear to respond consistently to sound. The developmental milestones listed for children in this age reflect speech/language development. These children should also respond to sound awareness, localization, discrimination and recognition.

A more in depth health history can be completed using SECTION TWO. So that appropriate referrals are made using SECTION TWO, it is recommended that the screener attend the HVC training. SECTION ONE can be administered with or without SECTION TWO.

SECTION ONE

Functional Hearing Screening: BRIEF HEALTH HISTORY

YES NO

- | | | |
|--------------------------|--------------------------|---|
| <input type="checkbox"/> | <input type="checkbox"/> | Do others in the family, including brothers or sisters, have a hearing problem? |
| <input type="checkbox"/> | <input type="checkbox"/> | The child's mother had medical problems in pregnancy or delivery (serious illness or injury, drugs or medications). |
| <input type="checkbox"/> | <input type="checkbox"/> | The baby was born early (premature). Weight at birth: _____. |
| <input type="checkbox"/> | <input type="checkbox"/> | The baby had physical problems at birth. |
| <input type="checkbox"/> | <input type="checkbox"/> | The child rubs or pulls on ear(s) often. |
| <input type="checkbox"/> | <input type="checkbox"/> | The child had scarlet fever. |
| <input type="checkbox"/> | <input type="checkbox"/> | The child had meningitis. |
| <input type="checkbox"/> | <input type="checkbox"/> | The child had _____ ear infections in the past year. |
| <input type="checkbox"/> | <input type="checkbox"/> | The child has colds, allergies, and ear infections, once a month _____ more often _____.
(Consult with primary care physician prior to authorization of audiological examination) |

SECTION ONE

**Functional Hearing Screening:
DEVELOPMENT BY PARENT REPORT**

Birth to 3 Months

YES NO

- Reacts to loud sounds.
- Is soothed by your voice.
- Turns head to you when you speak.
- Is awakened by loud voices and sounds.
- Smiles when spoken to.
- Seems to know your voice and quiets down if crying.

3 to 6 Months

YES NO

- Looks upward or turns toward a new sound.
- Responds to "no" and changes in tone of voice.
- Imitates his/her own voice.
- Enjoys rattles and other toys that make sounds.
- Begins to repeat sounds (such as ooh, aah, and ba-ba).
- Becomes scared by a loud voice.

6 to 10 Months

YES NO

- Responds to his/her own name, telephone ringing, someone's voice, even when not loud.
- Knows words for common things (cup, shoe) and sayings ("bye-bye").
- Makes babbling sounds, even when alone.
- Starts to respond to requests such as "come here."
- Looks at things or pictures when someone talks about them.

10 to 15 Months

YES NO

- Plays with own voice, enjoying the sound and feel of it.
- Points to or looks at familiar objects or people when asked to do so.
- Imitates simple words and sounds; may use a few single words meaningfully.
- Enjoys games like peek-a-boo and pat-a-cake.

15 to 18 Months

YES NO

- Follows simple directions, such as "give me the ball."
- Uses words he/she has learned often.
- Uses 2-3 word sentences to talk about and ask for things.
- Knows 10 to 20 words.

18 to 24 Months

YES NO

- Understands simple "yes-no" questions (Are you hungry?).
- Understands simple phrases ("in the cup," "on the table").
- Enjoys being read to.
- Points to pictures when asked.

24 to 36 Months

YES NO

- Understands "not now" and "no more."
- Chooses things by size (big, little).
- Follows simple directions such as "get your shoes" and "drink your milk."
- Understands many action words (run, jump).

If a child in the 10-36 month age range does not appear to respond to sound consistently, provide a brief explanation of the concerns _____

SECTION TWO

**Functional Hearing Screening:
IN DEPTH HEALTH HISTORY**

Child's Name _____ Today's Date _____

The purpose of this section is to identify risk indicators which would indicate the need for an audiological examination.

Family History: Relatives who had onset of a hearing loss during childhood should be identified. A family history of hearing loss can be a strong indicator of genetic hearing loss.

Prenatal History: Maternal health can affect a child's hearing. High fevers, ototoxic medications and certain infections can affect hearing.

Birth History: Certain indicators and interventions at birth can impact hearing not only at birth but also later in childhood.

Medical History: As with maternal health, high fever, ototoxic medications, and certain infections can effect a child's hearing. Newborn hearing screening results should be documented including the birth hospital, audiologist and / or physicians. Any concern related to hearing should also be identified.

Check any that apply and give a brief explanation.

Family History

Parental concern regarding hearing _____
Family member had onset of a hearing loss during childhood. Please give the individuals relationship to the child _____

Prenatal History

Mother ill during pregnancy _____
Mother on medication during pregnancy _____

Birth History

Birth weight under 5 lbs. Indicate infant's birth weight _____
Respiratory concern at birth _____
Jaundice requiring blood transfusion or re-admittance to the hospital _____
Neurological concern at birth _____
Abnormal finding of the head or neck _____
Hospitalized more than 2 days. Indicate length and reason for stay _____
Failed newborn hearing screening _____
Indicate birth hospital _____
Follow-up location _____

Medical History

Childhood illness _____
Medications (other than over-the-counter) _____
Hospitalizations _____
Repeated ear infections _____
Ear surgery _____
Head trauma _____
Chemotherapy _____
Other-explain _____

ENT _____ Audiologist _____

Hearing Aids/Accessories in the Early Intervention System

General Information

- Refer to the Hearing Service Guidelines located on the Hearing and Vision Early Intervention Outreach website at:
<http://www.morgan.k12.il.us/isd/hvc/documents/guidelines/hearing.pdf>
- Early Intervention pays for hearing aids *prior* to ALLKIDS and *after* Division of Specialized Care for Children (DSCC) or personal insurance has been maximized.

Protocol

- The Service Coordinator at the local Child and Family Connections office must complete the eligibility screening to determine if the child/family may be eligible for DSCC or ALLKIDS. If eligible, referral is made prior to requesting EI approval for Assistive Technology.
- If it is clear that the family will not be DSCC-eligible according to available DSCC financial eligibility guidelines, the request for Early Intervention Assistive Technology may be submitted to prevent delay in obtaining hearing aids for a child.
- The family must use an EI enrolled audiologist.
- The Service Coordinator or AT coordinator is responsible for assembling the Individual Family Service Plan team ensuring that the need for hearing aids is appropriately related to one or more of the child's functional outcomes and is documented in the IFSP. 'Hearing Aids' should not be an outcome statement, but rather a strategy that supports an outcome. The service coordinator or the Assistive Technology (AT) coordinator should work closely with the EI enrolled audiologist to assure that the necessary components of the Assistive Technology packet are obtained, and submitted to the Assistive Technology Coordinator at the Bureau for approval.
- Refer to the Early Intervention Assistive Technology Guidelines included in the Service Coordinator Manual for complete information and forms.
- The Assistive Technology packet is composed of:
 - AT request form
 - Levels of Development pages from IFSP
 - IFSP Outcome page(s)
 - Letter of Developmental Necessity, written by an EI enrolled Audiologist
 - Medical clearance/script from the physician
 - Vender quote on letterhead (if not included with Letter of Developmental Necessity)
 - Manufacturer price list
 - DSCC eligibility denial letter, if applicable

- Hearing Evaluation Report/Audiogram.
- Consent for Release of Information-Children with Identified Hearing Loss
- Family Fee report, if not HFS/Medicaid eligible

Hearing Aids/Accessories in the Early Intervention System

- All documentation submitted for an AT request must be signed and dated within six months of receipt of the AT request by DHS.
- The AT review process may take up to 30 days for approval once a complete Assistive Technology packet/request is received at the Bureau of Early Intervention. If an incomplete packet is submitted, the approval time could take longer.

Hearing Aid Rates:

- Maximum allowable rates have been determined by Early Intervention for hearing aids. DSCC rates are followed but a cut back is not taken by EI.
- Hearing aids are paid at 1.5 times the wholesale single unit cost.
- Shipping and handling is not covered by EI.
- The following services are authorized separately with written justification and paid at Medicaid rates.

V5160	Hearing aid dispensing fee: binaural	\$349.68
V5241	Hearing aid dispensing fee: monaural hearing aid, any type	\$217.14
V5010	Hearing aid assessment	\$66.69
V5264	Hearing aid ear mold/insert not disposable, any type	\$37.26
V5266	16 batteries every 60 days	\$1.56 each
V5267	Hearing aid clip	25% over retail
V5267	Hearing aid supplies/accessories, i.e. pediatric care kit	Maximum \$50.00
V5267	Dry and Store Appliance	25% over retail

- Once the Bureau notifies the Service Coordinator of approval, the SC notifies the audiologist by sending the authorization for the hearing aids. The audiologist/vendor may proceed with ordering the aids.

Hearing Aid Checks

Once a child's hearing aids have been dispensed, meaning that all follow up visits to provide instruction to the family and to measure, fit and adjust the hearing aid(s) to work most appropriately for the child, EI will pay for hearing aid checks every three months, or more frequently if the Audiologist provides a written justification of need to the child's service coordinator. The justification does not have to be written on a particular form, but must be sent to the service coordinator to justify and request an authorization. The new procedure codes and rates include the following:

Code	Procedure	Rate
92592	Hearing aid check; monaural	\$15.20
92593	Hearing aid check; binaural	\$15.20
92594	Electroacoustic evaluation for Hearing aid; monaural	\$15.20
92595	Electroacoustic evaluation for Hearing aid; binaural	\$15.20

- A Hearing Aid Check (EIHAC) authorization will be allowed for one occurrence only per authorization.
- No procedure codes will print on the authorization.
- EIHAC will print on the authorization instead of procedure codes.
- The audiologist will be allowed to bill up to two procedure codes on one authorization.
- The audiologist will choose either binaural or monaural codes to bill. NOTE: Do not bill two codes unless you completed two procedures.
- The audiologist may have an EIHAC authorization at a minimum of every three months. If it is identified that a child may need to have a hearing aid check prior to three months from the date of the previous check, the audiologist must submit a written justification of need to the child's service coordinator to request an authorization. NOTE: EI will not pay for hearing aid checks more than one time per month. The audiologist is required to submit a written document to the service coordinator to justify receipt of an EIHAC authorization if a hearing aid check is needed prior to three months from the previous check.

Hearing Aids/Accessories in the Early Intervention System

- When replacement ear molds are needed, the Audiologist contacts the Service Coordinator to authorize, without prior approval from the AT coordinator. A Letter of Developmental Necessity and Medical Order/Script from the Physician must be kept in the file at the CFC office. Earmolds are authorized no more than two per authorization at the rate above.

- Hearing aid batteries may be authorized at 16 batteries every 60 days at the rates mentioned without prior approval from the AT Coordinator. The letter of Developmental Necessity must be kept in the file at the CFC office.
- When repairs to a hearing aid are needed, the Service Coordinator faxes an AT Request Form and a repair quote from an enrolled audiologist to the AT Coordinator. Upon Bureau approval, the Service Coordinator may generate the authorization for repair.