UW Speech and Hearing Clinic
UNIVERSITY OF WISCONSIN–MADISON

Goodnight Hall
1975 Willow Drive
Madison, WI 53706
Phone: 608-262-3951
Fax: 608-262-6466

WISHES PARENT USE AGREEMENT

Date of Request:	
Child's Name:	
Date of Birth:	
Sex:	☐ Male ☐ Female
Parent/Legal Guardian:	
Mailing Address:	
Phone:	
Email:	

Briefly state why assistance is being requested:

____

____

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Primary purpose for amplification need: Check only one.

☐ Education – participating in any type of educational program, including Birth to 3 and local school district programming.
☐ Community living – carrying out daily activities, participating in community activities, using community services, or living independently.

Primary reason for request: Check only one.

☐ I could only afford amplification through this program.
☐ Amplification was only available to me through this program (I am not eligible or don't qualify for other programs, amplification is not covered by other funding sources or the specific device/s needed were not provided by other programs.)
☐ Amplification was available to me through other programs, but the system was too complex or the wait time was too long.
☐ Other: ____

Insurance Information: Check the one that best describes your situation.

☐ I / We do not have any insurance and are not eligible for state assistance programs like Medicaid or Badger Care.
☐ I / We have health insurance, but do not have any hearing aid coverage and need to obtain funding assistance.
☐ I / We have health insurance, but have only partial hearing aid coverage and need to obtain additional funding assistance.
☐ I / We are considering a cochlear implant for our child and it is required that our child try amplification before candidacy can be determined.
☐ My / Our child has been diagnosed with Auditory Neuropathy Spectrum Disorder (ANSD) and it is recommended that our child try amplification to determine effectiveness.

Responsible Parent/Guardian agrees to the following:

- I/ We will care and maintain the hearing aids.
- I / We will seek permanent amplification for our child.
- I / We understand that we may be held responsible for any loss or damage to the amplification not covered by the device warranty up to $100.00 each. This excludes normal wear and tear.
- I / We will return the hearing instruments to my child's audiologist in good working order upon expiration of the 6 month loan period or when my child receives their own personal amplification; whichever occurs first. I understand that I / We can request a 3 month extension if necessary.
- I / We have signed a Release of Information consent form with our child's audiologist that will allow him/her to discuss any necessary information related to the amplification requested for our child with the WISHES Program.

WISHES Program may send / email me additional information on events or activities related to Deaf and Hard of Hearing Children (No information will be disclosed to outside sources):

☐ YES ☐ NO

Parent/Guardian Signature: ________________________________

Audiologist Signature: ________________________________

Date signed: _____/_____/_____

Please submit all required information to:
Amy Hartman, Au.D.
1975 Willow Drive, Room 373
Madison, WI 53706
wishes@csd.wisc.edu