Enable NEW ZEALAND

HEARING EQUIPMENT FORM EXPLAINED

All boxes will expand to accommodate the required information.

DIAGNOSIS: only indicate the Diagnosis relevant to this application not all past medical history.

Describe the person, their environment and the issues they are facing. Keep information relevant to the application.

The form can be 'unlocked' to allow customised Assessor details.

PRIMARY DISABILITY TYPE: These boxes are for reporting purposes. Only one should be selected.

EILIGIBILITY BOXES: these relate to the details on eligibility in the EMS manual.

Numbering will automatically change if the report goes over the page.

Enable NEW ZEALAND

HEARING EQUIPMENT

moh.processing@enable.co.nz Phone 0800 17 1995

OFFICE USE ONLY Client No: Assessor No: S/O No: Eligible Y ☐ N ☐

This application is being made for the purchase or trial of complex equipment. The Specialised Assessor is responsible for ensuring the person receiving the equipment has read and understood the equipment Information form and Authorises Enable New Zealand to use/disclose information as described in the Privacy Act Statement. P

CLIENT DETAILS		SPECIALISED ASSESSOR DETAILS	
NHI		Name	
Family Name		AEA No:	
First Name		Email	
Street Address		Phone	
Town/City		Fax	
Postcode		Mobile	
Telephone		Specialised Assessor Declaration: By completing and submitting this electronic application you confirm that the application is correct and meets the criteria in the current Ministry of Health Equipment and Modification Services Manual.	
Date of Birth			
Gender	☐ Male ☐ Female		
Ethnicity		DATE SENT	/ /

ELIGIBILITY

Diagnosis | Disability

Tick one box to indicate the best description for the persons primary disability type:

☐ Physical ☐ Intellectual ☐ Sensory ☐ Age Related

The equipment is essential for:

☐ Fulltime Education ☐ Main Carer
☐ Fulltime Employment ☐ Vocational Training
☐ Dual Disability ☐ Voluntary Work
☐ Remaining in the home *(HAT ONLY not for hearing aids)*

Resides:

☐ Own Home
☐ Residential Care Over 65
☐ Residential Care Under 65
☐ Lives Alone

ATTACHMENTS

☐ Itemised quotes ☐ Evidence of employment/education/vocational training

In addition all hearing aid applications MUST include the following information:

☐ Audiogram ☐ Client Oriented Scale of Improvement (COSI)

CONTEXT – *How the persons hearing loss impacts on the activities related to the eligibility criteria*

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The header line of client and assessor name will automatically repeat on subsequent pages.

Where the hearing aid is high or advanced level of technology there must be accompanying additional justification.

Correspondence details – where the Audiologist works in several different clinics they need to identify the correct address for correspondence and delivery of the ordered equipment.

Rationale for the specific equipment selected must indicate how the equipment will meet the identified needs.

Please indicate if a trial of the equipment item is required.

Other options: Indicate the potential solutions which may have been possible, and the reasons why these have been discounted.

Client Name | Specialised Assessor

EQUIPMENT TYPE

☐ Hearing Aids | ☐ Unilateral ☐ Bilateral | Style | ☐ RITC ☐ BTE ☐ ITE ☐ ITC ☐ CIC ☐ IOT ☐ CROS ☐ BiCROS ☐ Other *(Please specify)*

Specific features | ☐ Direction fixed ☐ Directional adaptive ☐ NR ☐ Feedback control ☐ Other *(please specify)*

Level of technology | ☐ Basic ☐ Moderate ☐ High/Advanced *(additional rationale required)*

What are the ear, health and/or environmental factors that influence the style or model of hearing aids proposed?

Supplier	Brand/Model	Supplier Code	*How will the Hearing aid meet the identified needs?*	Trial	Office Use
				☐	
				☐	

Accessories Supplier	Brand/Model	Supplier Code	*How are these accessories essential to meet the identified needs?*	Trial	
				☐	
				☐	

☐ Hearing Equipment Supplier	Brand/Model	Supplier Code	*Why is this item of equipment essential to meet the identified needs?*	Trial	
				☐	
				☐	
				☐	

OTHER OPTIONS – *Description of potential other solutions to address the identified needs, and details as to why these are not suitable.*

DELIVERY DETAILS				CORRESPONDENCE DETAILS *(clinic address)*	
Street Address		Phone		Mailing Address	
Town/City		Instructions		Town/City	

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