Hearing Aid Loan Extension Form

The purpose of this program is to provide temporary hearing aids for Maryland residents with hearing loss under the age of 21 years old who have not yet graduated from high school while they are waiting to receive their personal amplification devices. The best way to contact the loan bank is through email. Please contact the Hearing Aid and Language & Communication Video Loan Bank at zella.shabasson@maryland.gov or 410-767-0739 if you have any questions.

This application is for the purpose of extending the initial 12-month loan for a period of up to 12 additional months.

Please complete Parts A-C of this application and return to:
Maryland State Department of Education
Division of Special Education
200 West Baltimore Street, 9th Floor
Baltimore, Maryland 21201
ATTN: Zella Shabasson
Email: zella.shabasson@maryland.gov
Fax: (410) 333-8165

The Application can be saved and submitted electronically, printed and mailed, or faxed. The information contained on this form will be kept confidential.

Part A

CHILD'S INFORMATION

Name:

Date of Birth:

Parent/Legal Guardian Name:

Mailing Address:

City, State, Zip:

Home Phone Number:

Cell Phone Number:

Parent's Email Address:

Date Submitted:

Part B

TO BE COMPLETED BY THE PARENT OR LEGAL GUARDIAN

1. Please describe why you need to extend the hearing aid loan for your child and have been unable to access personal hearing aids for your child in the past twelve months.

2. Do you need information regarding resources to secure permanent hearing aids?

Part C

HEARING AID LOAN EXTENSION AGREEMENT

TO BE COMPLETED BY THE PARENT OR LEGAL GUARDIAN

Check each box to confirm agreement with the statement.

- ☐ I AGREE THAT MY CHILD WILL RECEIVE (A) LOANER HEARING AID(S) FROM THE MARYLAND STATE DEPARTMENT OF EDUCATION, DIVISION OF SPECIAL EDUCATION.
- ☐ **I AGREE THAT IT IS MY RESPONSIBILITY TO MAINTAIN AND CARE FOR THE HEARING AID(S) AND THAT I WILL BE RESPONSIBLE FOR ANY LOSS OR DAMAGE NOT COVERED BY THE HEARING AID WARRANTY UP TO $150.00. THIS EXCLUDES NORMAL WEAR AND TEAR.**
- ☐ I AGREE THAT MY CHILD WILL HAVE USE OF THIS/THESE HEARING AID(S) FOR UP TO 12 ADDITIONAL MONTHS.
- ☐ I AGREE TO SEEK PERMANENT HEARING AID(S) OR COCHLEAR IMPLANT FOR MY CHILD.
- ☐ I AGREE THAT WHEN MY CHILD RECEIVES THEIR PERSONAL AMPLIFICATION, I WILL RETURN THE LOANER HEARING AID(S) TO MY CHILD'S AUDIOLOGIST TO BE RETURNED TO THE LOAN BANK.

Parent/Legal Guardian Signature

Date

Requesting Audiologist Signature

Date