Potential Infant Audiological Assessment & Diagnostic Center Questionnaire

Date: _____

Applicant Agency Information

Agency Name:		
Authorized Contact:	Title:	
E-mail Address:	Authorized Contact Phone:	
Agency Physical Address:		
City:	State:	Zip:
Mailing Address (if different):		
Agency Phone:	Toll-free:	Fax:
Medicaid-Approved Provider?	☐Yes	☐No
First Steps Provider?	☐Yes	☐No
Approval Level Requested	☐Level 1	☐Level 2

Population Served

Please check all age ranges for whom your facility provides diagnostic audiology services.

☐ Birth to 3 months ☐ 3 to 6 months ☐ 6 to 9 months ☐ 9 to 12 months
☐ 12 to 24 months ☐ 24 to 36 months ☐ Over 36 months ☐ None of the above

Audiological Services Provided

Please check all services which your facility provides for infants & toddlers.

Immittance Measures (Tympanometry & Acoustic Reflex Thresholds)

☐ 226 Hz ☐ 1000 Hz
☐ High-frequency ☐ Multi-frequencies

Otoacoustic Emissions

☐ Distortion Product ☐ Transient Evoked

Behavioral Testing

☐ Visual Reinforcement Audiometry ☐ Conditioned Play Audiometry

Auditory Brainstem Response

☐ Screening only (AABR) ☐ Air Conduction Click Threshold
☐ Bone Conduction Click Threshold ☐ Tone Bursts/Pips
☐ Frequency-specific ☐ Neuro-diagnostic

Intervention Services

☐ Amplification selection & fitting ☐ Cochlear implant services
☐ Speech-language pathology ☐ Aural habilitation
☐ Amplification verification: probe microphone ☐ Amplification verification: functional gain
☐ Medical: primary care physician ☐ Medical: ENT
☐ Social services or counseling ☐ Other: _____

Sedation

Is sedation available at your facility? ☐ Yes ☐ No

At what age does your current policy & procedure recommend sedation for ABR?

☐ Birth to 3 months ☐ 3 to 6 months ☐ 6 to 9 months ☐ 9 to 12 months
☐ 12 to 24 months ☐ 24 to 36 months ☐ Over 36 months ☐ NA

Continued on Reverse

Potential Infant Audiological Assessment & Diagnostic Center Questionnaire

Agency Name:

List All Licensed Audiologists

Name & Credentials	KY License
	KY License #:
	KY License #:
	KY License #:
	KY License #:
	KY License #:
	KY License #:
	KY License #:
	KY License #:

List All Audiology Externs

Name	University	Supervisor Name

Required Attachments

Pursuant to 911 KAR 1:085, a complete application packet includes this form and the following attachments:

☐ Copies of current professional licenses for audiologists performing evaluations
☐ Copies of current calibration certificates for audiological testing equipment
☐ Copies of policies and procedures for tests and measures performed

Assurances

On behalf of the applicant agency named above, I have reviewed this request for approval as an Infant Audiological Assessment and Diagnostic Center and certify that my answers are true and complete to the best of my knowledge.

Subject to approval as an Infant Audiological Assessment and Diagnostic Center, the applicant agency agrees to the following provisions as set forth in KRS 211.647 and 911 KAR 1:085:

? Report results of audiology evaluations (children birth to 3) to CCSHCN within 48 hours;
? Report all First Steps referrals to CCSHCN;
? Maintain active professional licensure for audiologists;
? Maintain annual calibration on audiological testing equipment in compliance with ANSI methods; and
? Notify CCSHCN of any changes in staff, licensure status, move, or policy & procedure.

_____ _____
Authorized Contact Signature Date

When complete, please submit this form, with all attachments to:

CCSHCN: Early Hearing Detection & Intervention
310 Whittington Parkway, Louisville KY 40222