DIVISION OF SPECIALIZED CARE FOR CHILDREN

EARLY HEARING DETECTION AND INTERVENTION PROGRAM DIAGNOSTIC EVALUATION SUMMARY

This prior approval is limited to outpatient examinations and/or audiological evaluations needed to confirm a diagnosis suspected on the basis of an abnormal newborn hearing screening test. It is to be used solely for those infants referred by the Illinois Department of Public Health's Early Hearing Detection and Intervention Program.

To be completed by Parent/Guardian: *(instructions on reverse side of form)*

1. Child's Name: _____ (Last Name), _____ (First Name) 2. Birthdate: _____ 3. Sex: M ☐ F ☐
4. Parent *(Mother / Father)* / Guardian Name: _____ (Last Name), _____ (First Name) 5. Birthing Facility: _____
6. Home Address: _____ (Street) (City) (State/Zip) (County)
7. Daytime Telephone: (_____)_____ Work ☐ Home ☐ Cell ☐
8. Family's Primary Language: English ☐ Spanish ☐ Other ☐ _____
9. **My Child:**
   Lives in Illinois? Yes ☐ No ☐ Has All Kids/Medicaid benefits? Yes ☐ No ☐
   Has private insurance benefits? Yes ☐ No ☐ Managed Care Organization: _____

I request assistance from the University of Illinois Chicago, Division of Specialized Care for Children (DSCC) for my child's special diagnostic evaluation.

I understand there will be no direct cost to me for this evaluation.

If I have medical insurance or All Kids/Medicaid benefits which cover my child, I understand that those benefits must be used first.

I understand that if additional assistance is needed from DSCC following this evaluation, I must submit a separate application.

I authorize DSCC to provide a copy of the necessary data to the Illinois Department of Public Health for the Early Hearing Detection and Intervention Program follow-up/tracking purposes.

_____ _____
Signature of Parent/Guardian *Date*

To be completed by Evaluator: *(instructions on reverse side of form)*

10. Audiologist _____ 11. Initial Date of Service _____
12. Audiologist's Hospital/Clinic _____
13. Child's Primary Care Provider _____ 14. Referring Provider _____

DIAGNOSTIC EVALUATION SUMMARY *(attach full report(s))*

15. Hearing Status: **Left Ear:** ☐ Inconclusive ☐ Normal ☐ Confirmed Loss Type:
    (☐ Conductive ☐ Sensorineural ☐ Mixed ☐ Other ☐ Mild ☐ Moderate ☐ Severe ☐ Profound)

    Hearing Status: **Right Ear:** ☐ Inconclusive ☐ Normal ☐ Confirmed Loss Type:
    (☐ Conductive ☐ Sensorineural ☐ Mixed ☐ Other ☐ Mild ☐ Moderate ☐ Severe ☐ Profound)

16. If Inconclusive, Date(s) of Next Evaluation(s): _____

    Has this child been referred to a Medical Provider / ENT? Yes ☐ No ☐

17. Additional Comments: _____
18. No. of Evaluations Attached: _____ *(Send all evaluation reports; see #20 below.)* 19. _____ *Audiologist's Signature*

20. **Send this form NO LATER than 30 days from the initial date of service to:**
    Regional Office servicing the child's home community. If unknown, send to office closest to the child's home community. *(See reverse side for listing.)*

    Bills may be denied if this referral is not received in time.

21. **Send billing to:**
    Division of Specialized Care for Children
    Claims Services
    3135 Old Jacksonville Road
    Springfield, IL 62704
    (800) 322-3722 Fax (217) 558-0773

Instructions (Please print or type all information requested)

1. Child's legal name: last name, first name.
2. Child's birthdate: month/day/year.
3. Child's sex: male or female.
4. Parent or guardian's name: last name, first name.
5. Name of the birthing facility where the child was born.
6. Parent or guardian's mailing address: street, city, state, zip code and county.
7. Telephone number where parent/guardian can be reached during the day.
8. Family's primary language: English, Spanish or Other.
9. My Child *(check appropriate boxes)*: lives in Illinois; has private insurance benefits; has All Kids/Medicaid benefits; list Managed Care org.
10. Name of audiologist who performed the diagnostic evaluation.
11. Date of the initial diagnostic evaluation: month/day/year.
12. Name of the audiologist's practice (i.e., hospital or clinic name).
13. Name of the child's primary care provider.
14. Name of the provider *(person or agency)* who referred the child for the diagnostic evaluation.
15. Please select the appropriate hearing status of the child and (if known) the type and degree of confirmed hearing loss.
16. If the result is inconclusive, please enter the scheduled date of the next diagnostic evaluation, and whether or not the child is being referred to a Medical Provider/ ENT.
17. Please enter any comments on treatment recommendations or follow-up actions necessary.
18. Please enter the number of evaluations that are attached to this form.
19. Audiologist's signature.
20. Send this diagnostic evaluation report to the Regional Office serving the area of parents' residence. See list of Regional Offices below. Use mailing address for all DSCC Regional Offices. Report MUST be received within 30 days of initial date of service.
21. Send bills to Springfield address provided. Bills will NOT be paid if received more than 9 months from date of service.

DSCC Regional Offices

Mailing address:

(Specific Regional Office name from list)
Division of Specialized Care for Children
3135 Old Jacksonville Road
Springfield, IL 62704-6488

Fax (217) 558-0773

Regional Office Locations:

CHAMPAIGN
Fax (217) 244-4212

CHICAGO
Fax (312) 433-4121

LOMBARD
Fax (630) 424-0669

MARION
(618) 993-8929

MOKENA
Fax (708) 478-3850

OLNEY
Fax (618) 395-2902

PEORIA
Fax (309) 693-5306

ROCKFORD
Fax (815) 987-7891

ST. CLAIR
Fax (618) 624-0538

SPRINGFIELD
Fax (217) 524-2020

Civil Rights Act Statement

Services, financial assistance, and other benefits of the Division of Specialized Care for Children are provided on a non-discriminatory basis. No person participating in or wishing to participate in the Division's programs shall be denied benefits of the program or shall be discriminated against on the basis of sex, religion, race, color, national origin, or handicap not related to program eligibility. Individuals who believe that discrimination is being practiced by the Division of Specialized Care for Children may file a written complaint with the State of Illinois, Department of Human Rights, or the United States, Department of Education, Office of Civil Rights, or both.

State of Illinois
Department of Human Rights
100 West Randolph Street
Illinois Center, Suite 10-100
Chicago, IL 60601

United States Department of Education
Office for Civil Rights - Region V
401 South State Street, 7th Floor
Chicago, IL 60605
(312) 886-3456

Reporting to the Illinois Department of Public Health
The Illinois Early Hearing Detection and Intervention Act, 410 ILCS 213, requires health care providers to report the results of diagnostic evaluations and other services for children under six years of age with suspected or confirmed hearing loss to **the Illinois Department of Public Health** within seven days of the date of service. **Fax #: (217) 557-5324.**

Early Intervention Statement
Children under 36 months of age with a confirmed hearing loss must be referred to Early Intervention for appropriate evaluations/assessments. Please visit the Illinois Department of Human Services Locator at www.dhs.state.il.us to find the appropriate Early Intervention Child and Family Connections office by county/zip code that would serve the residence of the child/family or contact the **Bureau of Early Intervention**, **(217) 782-1981,** for assistance.