



Assistive Device Request

A. Worker Information

Name:	Date of birth:
Claim number:	
Address:	

B. Clinic Information

Billing Date:	Date :
Clinic:	
Licensed/Certified Service Provider Name:	
Mailing Address:	
Telephone:	Fax:

C. Type of Assistive Listening Device

Please check appropriate boxes	L	R	
FM system	<input type="checkbox"/>	<input type="checkbox"/>	
Amplified Telephone	<input type="checkbox"/>		
Infrared TV system	<input type="checkbox"/>		
<input type="checkbox"/> Other:			
Comments:			
Signature of Clinician:			

D. Cost Sharing

I agree that since the assistive listening device costs more than what YWCHSB will fund, I will solely be responsible for the additional cost.	
Signature of worker:	
YWCHSB amount: \$	Client amount \$

YWCHSB use only	
Approved: <input type="checkbox"/> Yes <input type="checkbox"/> No	Signature of adjudicator: