STATE OF RHODE ISLAND
EXECUTIVE OFFICE OF HEALTH AND HUMAN SERVICES
MEDICAID PROGRAM

DIRECTOR OF NURSES STATEMENT FOR HEARING AIDS

Member Name: _____

DOB: _____ MID: _____

The following questions are to be answered and signed by the Director of Nurses or Administrator for all patients in skilled nursing facilities when a hearing aid is considered for purchase through the Medicaid Program.

1. **Has the patient been wearing a hearing aid?**

Yes ____ No ____ If yes, how long? _____

2. **Do you feel this patient will utilize a hearing aid if the Rhode Island Medical Assistance Program authorizes the purchase of a hearing aid?**

Yes _____ No _____

3. **Are you of the opinion that this patient will derive sufficient social/medical benefits to justify the purchase of a hearing aid?**

Yes _____ No _____

Signature: _____

Facility: _____

Date: _____