



Texas Workforce Commission  
 Vocational Rehabilitation Services  
**Hearing Evaluation Report**  
**Hearing Aid Recommendations**

**Instructions**

To be completed by the audiologist or hearing aid specialist. Please complete all necessary fields on the form to ensure orders to the manufacturer maybe fulfilled.

**Participant/Customer Information**

|                |                |
|----------------|----------------|
| Customer Name: | Case ID:       |
| Phone:         | Date of birth: |

**Hearing Aid Recommendations**

**Information for Hearing Aid Dispensers**

VRS purchases hearing aids from contracted manufacturers. When evaluating VRS customers, please recommend the products that best meet the customer's needs from the manufacturers below. If the required product (or a comparable product) is not available from one of these manufacturers, contact the VRS counselor.

**Hearing Aid Manufacturer:**

|                                  |  |  |   |                                  |
|----------------------------------|--|--|---|----------------------------------|
| <input type="checkbox"/> Beltone | <input type="checkbox"/> GN ReSound      | <input type="checkbox"/> Signia/Sivantos   | <input type="checkbox"/> Sonova - Phonak  | <input type="checkbox"/> Starkey |
| <input type="checkbox"/> Oticon  | <input type="checkbox"/> Rexton/Sivantos | <input type="checkbox"/> Sonic Innovations | <input type="checkbox"/> Sonova - Unitron | <input type="checkbox"/> Widex   |

**Style of Hearing Aid(s):**

| Ear          | BTE/RIC                  | ITE-FS                   | ITE-HS                   | RITE                     | ITC                      | CIC*                     | CROS                     | None                     |
|--------------|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|
| <b>Right</b> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| <b>Left</b>  | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

\*Provide vocational justification for CIC purchase, such as additional benefits the CIC offers, how the CIC meets the educational or employment needs of the customer, and compatibility with other assistive technology (for example, telephone amplifiers and FM systems):

**Models of devices requested:**

**Right Aid:**

**Left Aid:**

**Rechargeable Battery:**     Yes     No

**Accessories:**

**Color and Color Code:**

**Receiver information:**

\*Note manual T-Coil activation is required – if one is not included in the model/style of the aid, vocational justification must be made below.

**Earmold Information**

| <b>Earmold Supplier</b>  | <b>Right</b>             | <b>Left</b>              |
|--|--------------------------|--------------------------|
| Earmold not needed or Dome will be used  | <input type="checkbox"/> | <input type="checkbox"/> |
| Earmold to be provided by Dispenser; Requesting VRS authorization/payment to Dispenser                               | <input type="checkbox"/> | <input type="checkbox"/> |
| Earmold to be provided by Hearing Aid Manufacturer; Requesting VRS authorization/payment to Hearing Aid Manufacturer | <input type="checkbox"/> | <input type="checkbox"/> |
| Style of mold (if applicable)  |                          |                          |
| Earmold Details:   |                          |                          |
| Full Shell:  | <input type="checkbox"/> | <input type="checkbox"/> |
| Half Shell:  | <input type="checkbox"/> | <input type="checkbox"/> |

**Additional Information**

|  |                          |                          |
|--|--------------------------|--------------------------|
|  | <input type="checkbox"/> | <input type="checkbox"/> |
|  | <input type="checkbox"/> | <input type="checkbox"/> |
|  | <input type="checkbox"/> | <input type="checkbox"/> |

**Pricing Information**

| <b>Description:</b> | <b>Manufacturer's List Price</b> | <b>VRS Cost</b> |
|---------------------|----------------------------------|-----------------|
| Right Aid           |                                  |                 |
| Left Aid            |                                  |                 |
| Earmolds            |                                  |                 |
| Accessories         |                                  |                 |
| Accessories         |                                  |                 |
| Accessories         |                                  |                 |
| Accessories         |                                  |                 |
| Accessories         |                                  |                 |

**Bill To Information:**

|                                       |                     |           |
|---------------------------------------|---------------------|-----------|
| Bill To: Texas Workforce Solutions VR | TWC Account Number: |           |
| Address:                              |                     |           |
| City:                                 | State: TX           | Zip Code: |
| Contact:                              | Phone:              |           |
| Email:                                | Fax:                |           |

**Ship To Information:**

|          |                     |
|----------|---------------------|
| Ship To: | Account Number:     |
| Address: |                     |
| City:    | State: TX Zip Code: |

|   |                                  |                       |                  |
|---|----------------------------------|-----------------------|------------------|
| Contact:  |                                  |                       |                  |
| Email:  |                                  | Phone:                |                  |
| <b>Justifications</b>   |                                  |                       |                  |
| Describe how the hearing technology recommended, along with accessories named above is expected to improve the customer's ability to hear and communicate more effectively in the areas identified below. |                                  |                       |                  |
| Work and training environments (VR):  |                                  |                       |                  |
| Daily independent living activities that might affect success by:   |                                  |                       |                  |
| Type or print examiner's name:  |                                  |                       |                  |
| Address:  |                                  | City:                 | State: ZIP code: |
| Telephone number:<br>( )  |                                  | Examination date:     |                  |
| Examiner's signature:<br><b>X</b>   |                                  |                       |                  |
| All information is to be treated as confidential.<br>Examinee has the legal right to see this report when the examinee requests.  |                                  |                       |                  |
| <b>TWS – STAFF ONLY</b>   |                                  |                       |                  |
| <b>Hearing Aid Dispenser Service Charge</b>   |                                  |                       |                  |
| <b>EAR</b>  | <b>MANUFACTURER'S LIST PRICE</b> | <b>SERVICE CHARGE</b> |                  |
| <b>Right</b>  |                                  |                       |                  |
| <b>Left</b>   |                                  |                       |                  |