- parent support group or communication with other parents of children with hearing loss.

- **Initiate the amplification process if appropriate.**
- **Obtain MEDICAL CLEARANCE from the infant's medical home prior to fitting hearing aids.**
- **Assist in application to Medical Assistance** to obtain hearing aids.
- **Specialty Evaluations:** Recommend, with Medical Home approval, appropriate specialty evaluations:
  - Pediatric otolaryngologist
  - Medical geneticist
  - Pediatric ophthalmologist
- **Referral to Early Intervention:** Once hearing loss has been identified, a referral should be made immediately, with parental permission if making direct referral, to Early Intervention services. Habilitation and intervention should proceed concomitantly with the medical evaluation of the hearing loss and should not wait for completion of the medical evaluation and findings.

e. Hearing Aid Evaluation

The child is considered to be a candidate for amplification if a permanent hearing loss of greater than 20 dB HL exists in one or both ears in the frequency regions critical for speech understanding (1000-4000 Hz).

Hearing aids for most children should include Direct Audio Input (DAI), telecoil (T) and microphone-telecoil (M-T) switches, should be flexible, and should have safety-related features such as tamper resistant battery and volume controls. Binaural amplification should always be provided unless there are clear contraindications for fitting an ear. In general, BTEs are the hearing aid style of choice.

Custom earmolds should be available at the time of the hearing aid performance verification in order to measure the Real-Ear to Coupler Difference (RECD). The RECD will allow the hearing aid gain and maximum output characteristics of the hearing aid to be preset in the hearing aid test box prior to the evaluation of the hearing aid on the child. Use of a prescriptive program for gain and output (e.g., DSL[i/o]) is essential. Choice of the hearing aid instrument should be based on the targets. Once the targets are verified (DSL and SHARP) and the device is fitted, ongoing monitoring of hearing levels and of the amplification should take place.

Whenever possible, verification of the hearing aid settings should be completed using probe microphone measurements.

RECDs should be reassessed as the infant grows or whenever new earmolds are made.

B. Early Intervention Referral Guidelines

1. Referrals from primary referral sources must be made no more than two days after the child has been identified as needing Early Intervention Services. 1-800 CONNECT LINE (1-800-692-7288) with parental consent for direct referral.

2. Once the legal authority that is administering the local Early Intervention Service agency (County MH/MR) receives the referral, it shall appoint a service coordinator,

who is responsible for coordinating all services across agency lines, and serves as a single point of contact in helping parents to obtain the services and assistance they need. The service coordinator shall make contact with the family as soon as possible but no later than two business days after receiving the referral. The service coordinator will make contact with the child's family to set up the initial home visit (intake).

3. The initial home visit shall be completed to determine the existence of previous evaluations and to recommend the need for referral for a Multi-disciplinary Evaluation (MDE) to determine or confirm eligibility and access early intervention services or tracking. The service coordinator will review all pertinent records and information on the child (i.e., review of written professional reports such as audiologist reports, hospital neonatal discharge information, physician reports etc.). The service coordinator will also interview the family or caregiver and review parental report information, identify concerns of the family, identify strengths and needs of the family, and determine the family's routines in order to identify the supports and services necessary to enhance the family's capacity to meet the developmental needs of the child.

4. In the event that the child is referred for an MDE and is found eligible for early intervention services, a meeting is scheduled to develop an Individualized Family Service Plan (IFSP) for the child. The IFSP is developed by the MDE team and authorizes services, as well as a description of the frequency, duration and location of such services. The service coordinator will continue to coordinate all activities with the family's primary care provider by asking parents for consent to send copies of pertinent information to their primary care provider (e.g., copy of the IFSP, MDE).

IV. Data Reporting to the Department

A. The IHEARR Act requires that hearing screening facilities provide the following data to the Department:

- *Newborn Hearing Screening Program Screening Reporting Form*—to be submitted weekly for each newborn not passing follow-up rescreening within 30 days of birth (see attached).
- *Monthly Report*—to be submitted by the 15th of every month by fax, mail or e-mail, covering births and screenings for the preceding month (see attached). Birthing facilities should update any incomplete data submitted on previous Monthly Reports with the submission of each new Monthly Report.

B. Audiologists shall send data to the Department concerning the results of diagnostic testing for all infants, who did not pass two independent screens within 30 days of birth, in a manner to be prescribed by the Department.