Alberta Government

Amplification Benefits Validation Certificate

Classification: Protected A (when completed)

Alberta Aids to Daily Living (AADL) Program

The information on this form is being collected and used by Alberta Health pursuant to sections 20, 21 and 22 of the *Health Information Act*, sections 33 and 34 of the *Freedom of Information and Protection of Privacy Act* (FOIP) and the Alberta Aids to Daily Living and Extended Health Benefits Regulations for the purpose of obtaining an AADL benefit. If you have any questions about the collection of this information, you can contact the Alberta Aids to Daily Living Program at Telus House, 13th Floor, 10020 – 100 Street NW, Edmonton, Alberta T5J 0N3; Telephone: 780-427-0731, Fax: 780-422-0968.

Instructions to Client:

1. Please sign your name, in full.
2. Ask for a copy of this form for your records.

Client's Name:_____ **PHN:**_____ **Authorization #:**_____

(Print name in full)

I acknowledge receipt of the following services:

	Assessment Date:	Client's Signature:
Hearing test:	_____	_____

I acknowledge receipt of the following equipment:

	Fitting Date:	Client's Signature:
Hearing Aid(s):	_____	_____
Personal Listening Device (PLD):	_____	_____
RM-HAT System:	_____	_____

I confirm, by my signature, that:

- Cost-sharing has been discussed with me. A device within AADL program maximum funding limits has been offered to me and I am aware that upgrade costs are my responsibility if I have chosen to purchase a more expensive product.
- I understand that my provider must provide me with a 28-day trial period with my equipment and provide a minimum of one follow-up appointment during that time. If I am not satisfied with the device at the end of my trial period, I am entitled to return it for a full refund, with the exception of custom earmolds, which may not be refundable.
- I am responsible for the care of the *device, **including obtaining insurance to replace the aid/device in the event that it is lost, stolen or damaged following termination of the manufacturer's original warranty.***
- I am not permitted to modify, adjust or repair my device and agree to consult with my vendor when these services are required.
- I am aware that I will not be eligible for further government funding for a **replacement** device for a period of five years from the date of this fitting. Repairs will be eligible for funding during this time.
- I am aware that the provider may bill AADL for my device if I refuse to return for my follow-up appointments and all efforts have been exhausted to warrant my return.

_____ / _____

(Client's Signature) (Date)

To be completed at end of 28-day trial period:

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Please **DO NOT** sign the following section of this form until **ALL** concerns regarding your amplification device are answered to your satisfaction by your vendor. If you are unable to sign this form, contact the AADL Program Manager to discuss the situation.

I have had the opportunity to complete a 28-day trial period with the following equipment. I am satisfied that my device is helping me to hear better in most situations.

	Trial Completion Date:	Client's Signature:
Hearing Aid(s):	_____	_____
Personal Listening Device (PLD):	_____	_____
RM-HAT System:	_____	_____

Vendor Name & Address:

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