State of North Carolina
Department of Health and Human Services
Division of Services for the Deaf and Hard of Hearing

ADDENDUM #2
NOTICE OF CONTRACT EXTENSION
CHANGES TO CONTRACT

Date: July 28, 2021
Contract Name: Request for Application – Telecoil-Equipped Hearing Aids
Contract Number: 30-DSDHH-95071-19
Contract Description: **Fitting and Servicing of Telecoil-Equipped Hearing Aids**

TERM:

This addendum officially extends the contract ending date until **August 31, 2022.** This contract extension represents optional year two (2) of the RFA released on August 1, 2019.

REVISIONS:

1. This addendum includes an attached list for providers to complete "listing of all clinics and providers (audiologists or hearing instrument specialists)". (See attached listing for providers to complete – Marked ATTACHMENT A).

2. ATTACHMENT H of the initial RFA is deleted in its entirety and replaced with the attached ATTACHMENT H included with this attachment.

3. All of the terms and conditions in the RFA released on August 1, 2019 and Amendment #1 released on or about August 1, 2020 shall remain the same.

Mail one (1) copy of all documents to:

Email questions to:
Becky.Rosenthal@dhhs.nc.gov

Division of Services for the Deaf and Hard of Hearing
Attention: Rebecca Rosenthal
820 S. Boylan Avenue
2301 MSC
Raleigh, NC 27699-2301

INSTRUCTIONS: Return one properly executed copy of the addendum by completing the information below. In addition, complete ATTACHMENT A and return with this executed addendum.

Execute Addendum	
Contractor	
Authorized Signature	
Name Typed or Printed	
Date	

Addendum # 2 Acceptance (For DHHS use only)

By my undersigned signature, as an authorized representative of the Division of Services for the Deaf and Hard of Hearing, I hereby accept this executed Addendum #2.

By: _____

Signature of Authorized Representative

_____

Printed Name of Authorized Representative

_____

Title of Authorized Representative

ATTACHMENT A

Listing of Business's Licensed Audiologists or Hearing Instrument Specialists

Business Name				
Address of Business				
	Street Name or PO Box	City	State	Zip

Name of Licensed Audiologist or Hearing Instrument Specialist					
	Name	Email Address	Fax Number	Home Number	Cell Number

Name of Licensed Audiologist or Hearing Instrument Specialist					
	Name	Email Address	Fax Number	Home Number	Cell Number

Name of Licensed Audiologist or Hearing Instrument Specialist					
	Name	Email Address	Fax Number	Home Number	Cell Number

Name of Licensed Audiologist or Hearing Instrument Specialist					
	Name	Email Address	Fax Number	Home Number	Cell Number

Name of Licensed Audiologist or Hearing Instrument Specialist					
	Name	Email Address	Fax Number	Home Number	Cell Number

(Use additional pages if necessary)

CERTIFICATION AND DOCUMENTATION OF EQUIPMENT NEED
To the Provider: All Fields MUST be Completed by the Hearing Aid Professional for Review by DSDHH

Select the appropriate box

◯ By signing below, I certify that I have assessed both ears of the applicant for hearing loss as documented on the attached audiogram and determined the applicant **MEETS** all hearing loss eligibility parameters established by DSDHH for this telecoil equipped hearing aid.

◯ By signing below, I certify that I have assessed both ears of the applicant for hearing loss as documented on the attached audiogram and determined the consumer **DOES NOT MEET** eligibility parameters established by DSDHH for a telecoil equipped hearing aid.

◯ By signing below and providing a ***letter of justification*** why applicant needs this device for telephone use and is alert, sufficiently oriented, and able to utilize and maintain a hearing aid properly and independently or with little assistance from another person. *(This is required if applicant **DOES NOT MEET** eligibility parameters established by DSDHH)*

Name of Applicant			
Certifier's name (PRINT)		License #	
Company Name:			
Street Address:			
City		State	Zip Code
Signature		Date:	
Approval send to:	Email or Fax (PRINT):		

PLEASE COMPLETE THE FOLLOWING IN ITS ENTIRITY (IF IT IS INCOMPLETE IT WILL BE REJECTED).

Hearing Aid Manufacturer: _____

Hearing Aid Model: _____

Check appropriate box below:

BTE Digital:		BTE Analog:		RIC:		RITE:		Other Style**	

***Other Style of Hearing Aid: The applicant requires another style of hearing aid for one or more physical reasons as noted in the attached documentation letter (Provider must submit a detailed explanation on company letterhead describing the need of style change).**

Bilateral Hearing Loss: _____ Yes _____ No

Better Ear Fit for Telephone Use: Right _____ Left _____

Ear Mold Type: □ Custom Occluded Style (specify) _____

□ Non-Occluded Style (i.e. domes) (specify) _____

Pure Tone Average at 500 Hz, 1000 Hz, and 2000 Hz: Right Ear _____ Left Ear _____

Pure Tone Average at 2000 Hz, 4000 Hz,6000Hz, and 8000 Hz: Right Ear _____ Left Ear _____

Audiograms must show evaluation results of both ears. Exceptions for single ear only evaluation must be explained on company letterhead and provided to the customer along with the audiogram and this form)

Additional Technology:

The recipient used the following type of mobile device for telecommunication (Fill out appropriate box)

IOS	**Android**	Other Mobile Device	Does not use a
iPhone, iPad, iPod	Make: _____	Specify: _____	Mobile Device _____
Generation: _____	Generation: _____		

Based on Hearing Aid brands provider distributes, and recipient needs, the following additional technology will be provided (Check one)

	MFI		**MFA**	**Bluetooth** Will you provide a phone streamer? If yes, which Streamer? _____	**Telecoil (T-Coil) MUST be provided**