



**Program for Amplification for Children of Texas (PACT)  
Application**

File # \_\_\_\_\_

Date \_\_\_\_\_

Telephone # \_\_\_\_\_

Legal Name of Applicant	Applicant's Father's Name	Applicant's Mother's Name
Applicant's Birth Date (MM/DD/YYYY)	Applicant's Complete Address (include street or PO box, city <u>and</u> zip code)	
Applicant's Medicaid #	Father's Medicaid #	Mother's Medicaid #
Applicant's Social Security #	Father's Social Security #	Mother's Social Security #
Children With Special Health Care Needs Program ID # (if applicable)	# of People in Household	
Name of Hospital or Birth Facility Where Applicant Was Born:		
City Where Facility is Located:		

*As the parent/guardian/conservator/caregiver/social worker of the above named individual, I understand that I am completing an application to obtain a hearing aid from the Texas Department of State Health Services for use only by the above named individual.*

*The Texas Department of State Health Services may share the information I submit with other agencies concerned with the applicant's health and education.*

*Loss protection insurance is available for the hearing aid(s). Please ask your PACT Provider about this.*

*If the applicant no longer needs the hearing aid, it can be donated to PACT for use as a loaner hearing aid.*

\_\_\_\_\_  
**Parent/Responsible Party's Signature**

\_\_\_\_\_  
**Date**

Provider Name	School Name
Address	Address
Telephone # ( )	Telephone # ( )