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DHHS AND MECDHH / GBSD

Pediatric Audiology

Guidelines

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About Links in This Document

Throughout this document you will find **links** to online resources. If you are viewing this document in PDF form, you can click a link to go to that resource. However, if you are viewing a printed version of this document you can access these resources by using each link's accompanying *QR code* (example shown below). Each code will be outlined in the same color as the link it is associated with. To use a code, just open your smartphone's camera app and scan the code.

Purpose Statement

The purpose of this document is to provide both new and seasoned audiologists with a resource for best practices in pediatric audiology. This document will also provide guidance for navigating the various systems of support available to children who are deaf/hard of hearing and their families. This will include state-specific guidance related to Early Hearing Detection and Intervention (EHDI) reporting and early intervention referrals.

Terminology

Hearing differences may be described in many different ways (hearing difference, hearing loss, deaf, hard of hearing, etc.). Because children who are born with hearing differences have not experienced a "loss" in hearing, the Deaf/Hard of Hearing Community chooses not to incorrectly use the term "hearing loss" when discussing the hearing of those who are born deaf/hard of hearing. Instead, the terms "hearing levels", "hearing difference", and "deaf/hard of hearing" are commonly used. You'll see this terminology used interchangeably throughout this document when referring to a child's hearing.

Statement of Audiologist Qualifications

Audiologists providing pediatric audiology services in Maine must be licensed by the State of Maine. The judgment regarding the ability to provide a comprehensive infant audiologic evaluation is instrumentation-driven. Audiologists should have experience working with the pediatric population and have an understanding of the resources available to children and their families. An accurate infant audiologic evaluation necessitates appropriate audiologist training and experience using instrumentation and protocols designed to obtain the information necessary to provide timely identification and management of infants and children who are deaf/hard of hearing. Audiologists are expected to follow their professional code of ethics regarding their capability of providing such services. Audiologists working with the pediatric population should also be comfortable making appropriate referrals and reporting test results to the Maine Newborn Hearing Program. **Category A audiology facilities** are defined as those facilities with the equipment and expertise to accurately identify children ages 6 months and under. **Category B audiology facilities** are defined as those with the equipment and expertise to accurately identify children over the age of 6 months. Some facilities may be considered both Category A and Category B audiology facilities. If the audiologist does not have the expertise and instrumentation to follow these guidelines, the infant and family should be referred to a professional equipped for and experienced in infant audiologic evaluation.

Diagnostic Audiology

As per the Early Hearing Detection and Intervention (EHDI) 1-3-6 guidelines, all children who refer on their newborn hearing screening should be seen as soon as possible for a diagnostic evaluation. The diagnostic evaluation must be completed by 3 months of age. Additionally, children with **certain risk factors** who pass the newborn screening will require further monitoring of their hearing.

Minimum Requirements for Audiological Evaluation

The Maine Newborn Hearing Program outlines a best practice protocol for diagnostic evaluations for children on page two of **this document**.

Further guidance regarding establishing your clinic's ABR protocols can be found **here** and **here**.

Because it is common for children in our state to receive follow-up care (medical clearance from an ENT for hearing technology, hearing aid fitting) outside of the clinic completing initial diagnosis, a standardized approach to diagnosis is recommended to ensure continuity of care and reduce the number of follow-up appointments for the family. If the audiologist expects to refer the child to another provider for medical clearance or ongoing management of hearing levels/ technology, the following minimum standard diagnostic protocol is advised:

- Thresholds via **toneburst** ABR (to ensure equivalent comparison for confirmatory testing) for at least 2 frequencies in each ear
    - Ideally, all 4 frequencies (500, 1000, 2000, and 4000 Hz) should be evaluated. However, if only two frequencies can be obtained due to time or patient constraints, audiologists should strive for one lower frequency (i.e., 500 or 1000 Hz) **AND** one higher frequency (i.e., 2000 or 4000 Hz)
- A copy of waveforms should be sent directly to the audiologist who is receiving the patient

This approach is strongly recommended because the majority of clinics in the state utilize toneburst ABR testing to evaluate hearing status in infants. The most recent Joint Committee on Infant Hearing (JCIH) Position Statement (2019) acknowledges toneburst ABR as "the gold standard for estimating hearing thresholds in the infant" but notes that other stimuli/protocols (auditory steady state response, narrowband chirps) were emerging as possible alternatives. The Position Statement goes on to discuss some of the limitations of ASSR and notes that "future endorsement [of ASSR as a reliable measure of infant hearing] may be possible" pending additional research. Although additional research has emerged since the 2019 Position Statement was published, the Maine Newborn Hearing Program defers to JCIH as the governing body responsible for setting standards in EHDI, and awaits an updated Position Statement before adding ASSR to the state's recommended Best Practices Protocol.

Clinics may choose to utilize other test stimuli/protocols (ASSR, chirps), but must be prepared to adhere to the minimum standard protocol listed above for any child with a suspected or confirmed hearing difference if they cannot or will not be managing the patient fully in-house. Confirmation of hearing levels is necessary prior to hearing aid fitting, and results must be within 5-10 dB of initial thresholds to ensure the reliability of results. Additionally, ENTs may request that their in-house audiologists complete confirmation testing prior to providing medical clearance for hearing technology. If different test approaches are used across appointments, the child will likely need three or more appointments to obtain the results necessary to confirm their hearing levels. Use of a minimum standard protocol reduces the likelihood that 3+ appointments will be needed prior to hearing aid fitting.

Recommended Follow-up Timelines

Pediatric audiologists are encouraged to use their own clinical judgment to determine the best follow-up protocols for individual patients; however, the following serves as a starting point for developing in-house follow-up protocols or otherwise supporting an audiologist in determining how to structure appointment schedules for their patients. Audiology professional organizations do not have specific guidance in this area; these are sourced from two major pediatric audiology facilities: Boston Children's Hospital in Boston, MA (D. Stiles, personal communication, November 16, 2021) and Nationwide Children's Hospital in Columbus, OH (U. Findlen, personal communication, November 16, 2021).

Children with Otitis Media with Effusion (OME)

In surveying Children's Hospitals regarding their protocols, two approaches were found.

- Three months of "watchful waiting" as recommended by the American Academy of Pediatrics. If a child is not at risk for a communication or developmental delay, a child with conductive hearing loss secondary to OME may be scheduled for repeat audiological testing in three months.
    - A child with no other risk factors should be referred to their pediatrician for medical management of OME.
    - A child with risk factors for communication or developmental delay should be referred to an Ear, Nose, and Throat (ENT) specialist.
- Audiologists may also choose to shorten the window for follow-up to 6-8 weeks. Whether to refer to the pediatrician or to the ENT is up to the audiologist's discretion.
- Families should be counseled regarding next steps, including why a follow-up timeline and/or referral was chosen.

Follow-up for Children with Incomplete Audiometric Results

At minimum, thresholds should be obtained within the normal range (defined as thresholds of 15 dB HL or less) for both ears at 500, 1000, 2000, and 4000 Hz before discontinuation of testing. Children who have thresholds within normal limits (WNL) but have risk factors for developing hearing differences should be scheduled for follow-up testing as indicated on the **Risk Monitoring protocol**. For children with incomplete audiograms at the time of initial testing, the following recommendations for follow-up are provided:

If a child needs additional developmental time to complete the evaluation repeat testing in 3-4 months, or sooner at clinician's discretion. Families should be counseled about the need for follow-up testing to provide the child time to mature in order to be able to participate in testing. Counseling should include providing families with resources on how to prepare their child to participate in follow-up testing. The parent should be informed that partial test results are not sufficient to rule out a hearing difference, and the importance of returning for follow-up should be stressed.

Follow-up testing using a second tester is recommended if the child was unable to fully participate in the first evaluation. The audiologist should explain to the family why using a second tester may help their child participate more fully in the evaluation.

If two team tests are unsuccessful, the child should be referred for a sedated ABR. The importance of obtaining complete results as soon as possible should be explained to the family, in addition to providing details about what to expect before, during, and after a sedated ABR, to alleviate any anxiety surrounding this decision.

If a child has absent OAEs in the absence of middle ear pathology at the time of initial testing, this may warrant a more aggressive follow-up timeline. An explanation should be given to the family regarding why more aggressive followup may be indicated.

If there are significant concerns regarding the child's hearing and the child does not have any indication for middle ear pathology, follow-up testing should be scheduled as soon as possible. The family should be counseled regarding concerns for a hearing difference and the urgent need for follow-up testing should be explained. This may help the family prepare for the follow-up testing results. See the Referrals section below for support that is available for families as they journey through this testing process.

If at any time the follow-up testing cannot be performed at the initial facility and the family needs to be referred to a different facility for this testing, the reasoning behind this decision should be discussed fully with the family and their options for follow-up testing explained to them.

Returning for multiple follow-up tests can be a very difficult time for families. Sharing information with the family regarding why this occurs and how common this is may be helpful in increasing families' confidence in the testing protocols.

Follow up for Children with Identified Hearing Differences

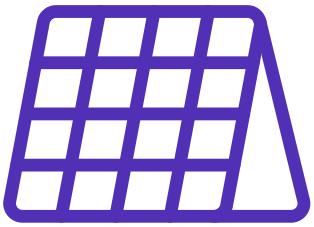
An Ear, Nose, and Throat (ENT) Doctor referral is needed after initial identification of a hearing difference. Families should be counseled regarding what an ENT provides and why their child is being referred there.

Confirmation of initial testing is recommended as soon as possible. Share with families why confirmation of the initial testing is needed and important.

Decisions regarding ongoing follow-up should be made based on the child's age, risk factors including risk factors for progressive hearing loss, and the judgment of reliability of test results. Share with families the timeline of future appointments and what information these future appointments will provide, as well as how they will help their child.

MNHP Reporting Requirements

FOR ALL MAINE PROVIDERS



REPORTING TO MNHP IS REQUIRED

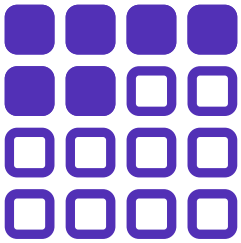
PARENTAL CONSENT IS NOT REQUIRED

Title 22 Maine Revised Statutes: Health and Welfare, Subtitle 6: Facilities for Children and Adults, Chapter 1686: Newborn Hearing Screening, Section 8824: Tracking system.

The **Maine Audiology Online Reporting Form** includes the minimum information necessary for reporting purposes. Audiologists are asked to provide as much demographic information as possible so that MNHP staff can contact families as necessary. Reporting of all hearing screening and diagnostic procedures completed for children from birth until their 4th birthday is mandatory per Maine law. Reports must be submitted at least monthly; ideally, reports should be submitted to MNHP within 5 days of testing. Parent/guardian consent to share this information with MNHP is not required. (22 Maine Revised Statutes Amended, §8824, 2007)

Child Development Services (CDS) / Early Intervention for Maine (EI for ME) Reporting

SUSPECTED OR CONFIRMED HEARING DIFFERENCES



MUST BE REPORTED WITHIN 7 DAYS

PARENTAL CONSENT IS NOT REQUIRED

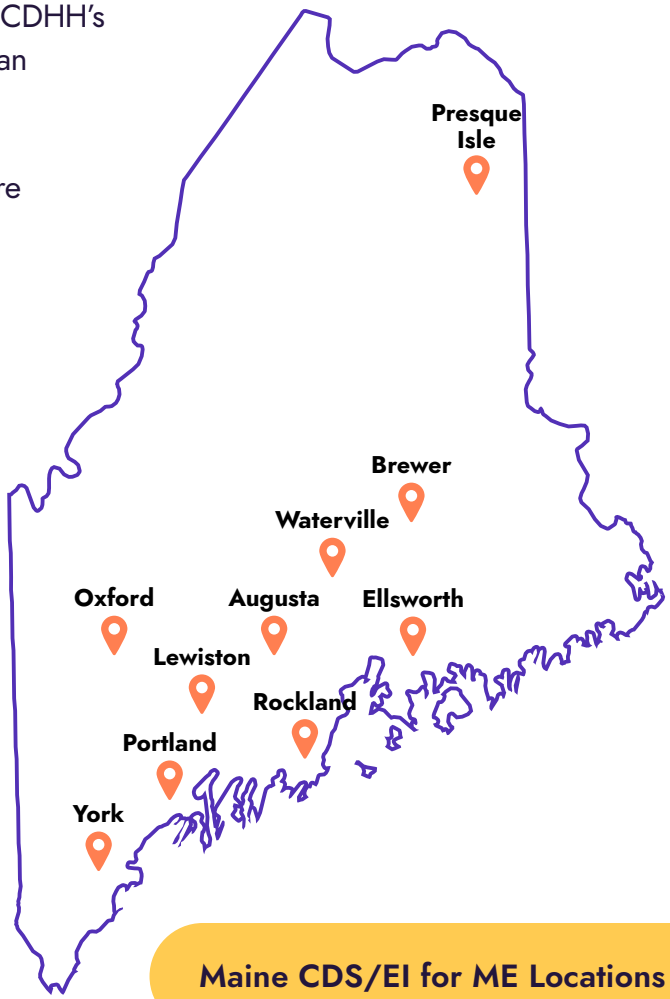
Requirements

Report suspected or confirmed hearing differences to the State **Child Development Services (CDS)/Early Intervention for Maine (EI for ME)** office within 7 days of diagnosis (MUSER 34 CFR 303.303(a)(2)(c)). Parental consent is not required for this federally mandated reporting (CFA 303.321d). Audiologists do not meet the legal requirement for referring to early intervention services by failing to refer when a parent indicates they will not accept CDS services; audiologists must still refer and parents should be counseled regarding the services provided by CDS. Parents can choose to decline services once contacted by CDS. This will include any report that is not noted to be "temporary conductive" in the type of loss field on the Audiology Online Reporting Form. Families can receive support even if their child is still going through the diagnostic process and a hearing difference is suspected. Audiologists **should not** wait for confirmation testing before making the referral to CDS/EI for ME.

CDS Child Find Intake Form

Maine Educational Center for the Deaf and Hard of Hearing (MECDHH) Referrals

Early Intervention Specialists from **MECDHH** are embedded into each CDS/EI for ME site across the state. This means that when a child is referred to CDS/EI for ME due to a identified or suspected hearing difference, the MECDHH provider is automatically included in the intake process. However, some families may indicate that they will decline CDS/EI for ME services, or there may be a family that would benefit from immediate connection with MECDHH. In these cases, audiologists can make a **direct referral** to MECDHH's Early Intervention and Family Services program. Families can receive support even if their child is still going through the diagnostic process and a hearing difference is suspected. Audiologists **should not** wait for confirmation testing before making the referral to CDS/EI for ME.



Maine CDS/EI for ME Locations

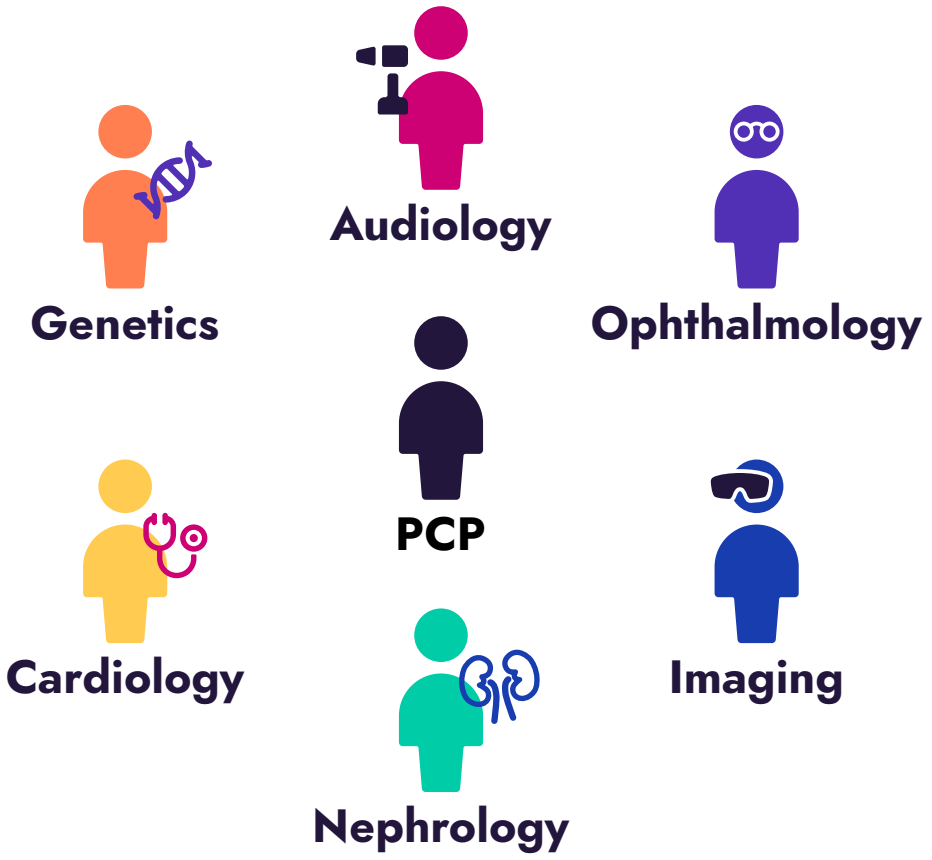
Maine Hands & Voices Referrals

Families of children identified as deaf or hard of hearing may be referred to the **Maine Hands & Voices** Guide By Your Side (GBYS) Program. The GBYS Program offers parent-to-parent support from Parent Guides, and DHH Adult-to-parent support from Deaf/Hard of Hearing Guides. Families can receive support even if their child is still going through the diagnostic process and a hearing difference is suspected. Audiologists may refer a family to GBYS to support them through this diagnostic process.

GBYS Referral Form for Parent Guide

GBYS Referral Form for DHH Guide

Communication with the Medical Home



Copies of the child's audiological evaluation reports should be shared with the child's primary care physician, family, and ENT for continuity of care. As the child's medical home, the PCP may be an appropriate referral source. Audiologist should recommend to the PCP the relevant referrals, such as genetics, ophthalmology, cardiology, nephrology, imaging, or other referrals as indicated by the patient's risk factors and diagnoses. Audiologist should be clear with the PCP which referrals will be made by the audiologist and which referrals the PCP will need to make.

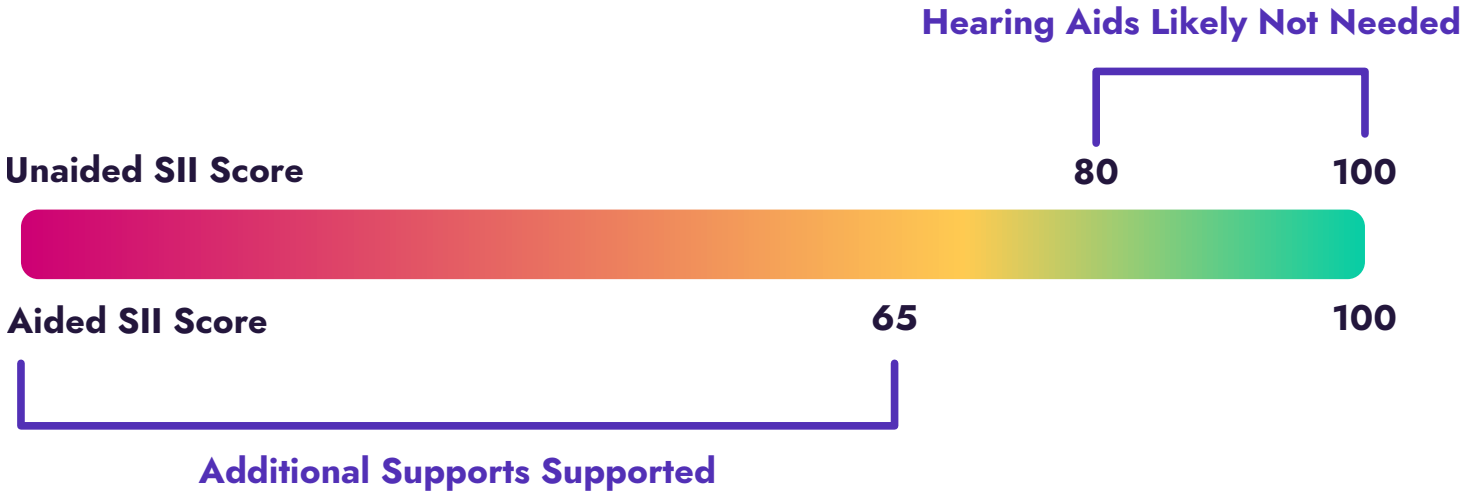
Hearing Technology

Statement of Audiologist Qualifications

Children in need of hearing aids should be served by audiologists with appropriate equipment for verifying the output of the hearing aids relative to the child's hearing levels, to ensure an appropriate fit using a valid prescriptive method. Hearing technology options will vary by clinic, but generally, audiologists should have working knowledge of the type of hearing technology they are fitting, with appropriate resources for support as needed.

Candidacy Considerations

Candidacy for hearing technology is first determined by the patient's audiometric results. In general, children with slight to profound hearing levels in one or both ears may be candidates for intervention using hearing technology. The unaided speech intelligibility index (SII) score can be a useful tool for assessing unaided audibility; a score of 80 or more has been associated with positive spoken language development outcomes, indicating that the need for hearing technology for children with **unaided** SII scores of 80 or above may not be significant. Conversely, **aided** SII values of 65 indicate the child may need additional supports which will differ based on the family's language and communication plan, as children with these scores often have poorer language outcomes. These additional supports can include visual language (American Sign Language, Cued Speech) and/or cochlear implantation.



Selection

The following are potential selection considerations:

Routing of signal: Given the type, degree, and configuration of the hearing levels, the patient may benefit from one of several types of hearing technology. Children with slight to moderate hearing levels and no outer/middle ear abnormalities may benefit from traditional amplification, while children with more significant hearing levels may be considered candidates for electrical stimulation. Children who may not benefit from traditional hearing aids given a significant conductive hearing difference and/or outer/middle ear abnormality may benefit from bone conduction devices. Contralateral routing of sound (CROS) or bilateral contralateral routing of sound (BiCROS) devices are also available for children with a hearing difference in one ear that is considered unaidable, to provide awareness of sound presented to that ear.

Hearing aid style: For those children who may benefit from traditional hearing aid technology, a behind-the-ear (BTE) hearing aid is considered the gold standard. The BTE provides flexibility as the child grows, allowing earmold remakes rather than the need to upgrade hearing aids frequently. BTEs also offer the widest range of features which may support a child's needs, including a broad fitting range to support changes in hearing, reduced feedback, ease of fitting a loaner hearing aid, and ability to connect with assistive technology devices.

Appropriate Earmolds: Earmold style and material should be selected based on individual patient needs. In general, soft material is recommended for comfortable wearing, reduced risk of damage to the ear, and improved retention. Caution should be taken when adding venting to earmolds for infants given the small canal size. Earmold impressions for this population should include a longer ear canal portion to reduce the impact of the occlusion effect (given the potential for small or no venting) as well as to increase output of the hearing aid given the reduced distance between the earmold and the eardrum. For more specifics regarding earmolds for pediatric populations, see the **Ontario 2019 Protocol for the Provision of Amplification, Appendix D**.

Safety: The audiologist must ensure that the hearing aid provided to the child is safe to use. This includes considerations related to the use of a tamper proof battery door, programming to avoid overamplification of sound, and counseling caregivers regarding safe and appropriate use of hearing technology.

Electroacoustic Characteristics: Considerations for various signal processing features can be found in the **American Academy of Audiology's Clinical Practice Guidelines for Pediatric Amplification**.

Ability to Connect with Other Assistive Technology: It is not uncommon for children to begin using remote microphone (RM) assistive technology when they enter the preschool setting at age 3; some children even begin using this technology during early intervention. Given this, it is crucial that children are fit with personal hearing technology that will easily connect with RM technology.

Hearing Aid Trials for Cochlear Implant Candidates: Children who are potential cochlear implant candidates should still receive a trial of hearing aid technology when indicated by FDA guidelines. Many of the above selection considerations apply to this patient population as well. These children should be referred to a cochlear implant center for evaluation to further determine their candidacy.

Amplification Goals

When providing amplification, several goals should be kept in mind:

- Provide consistent audibility
- Avoid distortion
- Offer the broadest possible frequency range
- Ensure comfort
- Provide sufficient flexibility for changes to technology as child grows
- Match output to target within +/- 3 dB from 250-8000 Hz during speechmapping at all three speech input levels (soft, average, loud) using real ear or measured real ear to coupler differences (RECD)
- Match real ear saturation response to target (within +/- 3 dB) and do not exceed predicted UCLs

Fitting

Once a child is determined to be a candidate for hearing technology, medical clearance from an otolaryngologist must be obtained in writing no more than 90 days before fitting (Maine Revised Statutes, Title 32, Chapter 137, §17305).

Prior to initial fitting and at each new earmold fitting, new probe-microphone RECD measurements must be obtained, and used to determine whether the hearing aid is meeting target for multiple input levels given their hearing levels and a prescriptive method appropriate for the pediatric population (i.e., NAL-NL1 or DSL v5). Electroacoustic verification using a hearing aid verification instrument must be performed to accomplish this task. Verification across multiple input levels (soft, average, and loud sounds) is recommended to determine how the child will access information in various listening environments. SII scores should be documented as part of the verification process, as these can be useful tools for predicting spoken language outcomes and may be requested by the child's early intervention team. Verification of hearing aid output is an ongoing process which must be repeated whenever there is a physical change to the child's hearing aid or earmold, or when adjustments to hearing aid gain are made. *(cont.)*

Recent research (Wiseman et al., 2023) indicates that calculating the average aided root-mean-square error (RMSE) for 500, 1000, 2000, and 4000 Hz is a useful tool for determining the effectiveness of a hearing aid fitting. This can be completed automatically using the Audioscan Verifit 2; for clinicians using other systems, this can be calculated manually by comparing the decibel level for Target and Hearing Aid Output at each of the four frequencies. The RMSE can then be calculated by taking the sum of the difference at each frequency and dividing by 4. An RMSE of 3 dB or less is recommended, and is correlated with better audibility for the hearing aid user. If a child's fitting deviates from this 3 dB RMSE benchmark, the audiologist can adjust output accordingly using the hearing aid software.

Follow-up

Following the fitting and orientation of hearing technology, the audiologist should complete outcome measures during subsequent appointments to ensure that the hearing technology is providing the predicted degree of benefit to the child. Outcome measures are available in a variety of formats, and can include behavioral speech perception testing, measures of access such as the Ling 6 HL Test, and parent questionnaires, such as the **Parents' Evaluation of Aural/Oral Performance of Children (PEACH)** or the **LittlEars**. Information gained from these outcome measures can guide further clinical decision-making and counseling to support the family and child.

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1 MACKWORTH ISLAND
FALMOUTH, MAINE 04105

207-781-3165 (VOICE) OR *207-449-1476* (VP)

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MAINE DEPARTMENT OF HEALTH & HEALTH & HUMAN SERVICES MAINE CENTER FOR DISEASE CONTROL AND PREVENTION MAINE NEWBORN HEARING PROGRAM

11 STATE HOUSE STATION,
AUGUSTA, MAINE 04333-0011

207-287-5357 OR *1-800-698-3624* (VOICE)
OR
TTY: *CALL 711* (MAINE RELAY)

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This project was supported by the Health Resources and Services Administration (HRSA) of the U.S. Department of Health and Human Services (HHS) as part of an award totaling $235,000 Award number H61MC30766 Maine Educational Center for the Deaf and Hard of Hearing, "Earliest interactions: Supporting 1-3-6 and Family Engagement". The contents are those of the author(s) and do not necessarily represent the official views of, nor an endorsement, by HRSA, HHS or the U.S. Government.

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Last Updated May 2025