

**The W. Paul Biggers
 Carolina Children’s Communicative Disorders Program
 5501 Fortune’s Ridge Drive, Ste. A
 Durham, NC 27713
 Phone 919-419-1449, Fax 919-419-1399**

PROGRAM APPLICATION

(Note: This form must be completed in full and will require the participation of the referring audiologist or professional. Please return it to the address above, accompanied by your most recent **STATE AND FEDERAL TAX RETURNS**, and the **GUARANTOR’S FINANCIAL STATEMENT**.)

Date: _____

1. Name of Patient: _____

2. Name of Parent(s) or Guardian(s): _____

3. Street Address: _____

City: _____ State: _____

ZIP: _____ County: _____

Telephone number (including area code): _____

4. Date of Birth: _____
(Month) (Date) (Year)

5. Gender: Male Female

6. UNC Hospital Unit Number (if patient has been assigned one): _____

7. Is the child covered by private health insurance? Yes No

8. Is the child covered by secondary health insurance? Yes No

9. **Please copy your insurance card(s) and attach to this application.**
(Note if either insurance company is a Managed Care Plan!)

10. Is child now covered at all by Medicare Medicaid CSHS
(If child is covered by Medicaid, please send documentation of benefits.)

11. Have you applied for Medicaid benefits and been turned down? Yes No
(If child is either covered or been denied coverage by Medicaid, please send documentation of benefits or a copy of the letter of denial.)

12. Onset of hearing loss: Congenital Acquired Age of onset _____

13. Age at first diagnosis of hearing loss: _____

25. Patient learned of the Carolina Children’s Communicative Disorders Program from (name of person, Institution, or other source): _____

26. Does the patient grant permission to the University of North Carolina Hospitals and the Carolina Children’s Communicative Disorders Program to use pictures, statements, and other documentary evidence of his or her participation in the CCCDP?

Yes No Signed _____

Please send a current photo of your child with this application. Any photo will do (can be an individual photo, or a photo with family or friends).

27. Dispensing Audiologist (**DO NOT LEAVE BLANK**): _____

Address: _____

Telephone Number (including area code): _____

28. Name and title of person completing this form (if different from above):

_____ Today’s date: _____

PLEASE CHECK HERE AND COMPLETE THE FOLLOWING
IF YOU ARE REFERRING A CHILD FOR A COCHLEAR IMPLANT EVALUATION:

29. Has the child ever been evaluated for a cochlear implant? Yes No

30. If yes, please specify place and date: _____

31. What was the recommendation from this evaluation? _____

32. Please give us the name, address and phone number of the child’s pediatrician.

PLEASE INCLUDE THE RESULTS OF ALL COCHLEAR IMPLANT EVALUATIONS
(AUDIOLOGICAL, SPEECH/LANGUAGE, OTOLOGICAL, PSYCHOSOCIAL, AND RADIOLOGICAL).

