The W. Paul Biggers MD
Carolina Children's Communicative Disorders Program

5501 Fortunes Ridge Dr. Suite A
Durham, NC 27713
Phone: 919-419-1449 / Fax: 919-419-1399

www.uncearandhearing.com

Dear Family,

Thank you for your interest in the Carolina Children's Communicative Disorders Program (CCCDP). The CCCDP financial assistance program provides funding for hearing aids for children with hearing loss whose families do not qualify for other public programs, and who do not have adequate income to obtain devices. Since 1993, the North Carolina General Assembly has provided this grant to assist families in the state who have children with hearing loss. North Carolina is the only state in the US to offer funding such as this for children with hearing loss. Remember to thank your legislators so that programs such as this can continue.

Children enrolled in the grant program must be North Carolina residents under 21 years of age. Acceptance is based on income, family size, other medical expenses, and the limitations of insurance and other resources. The financial criteria are somewhat flexible so that as many children as possible are served.

Please fill out the following application completely. You will need the assistance of your child's fitting audiologist to complete the form. Please note that while the program pays for hearing aids, it does not pay for loss or damage of the devices, or any fitting fees that your audiologist will charge.

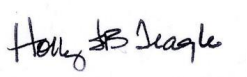
Remember to include the following as incomplete applications will not be considered:

- ❑ A copy your child's insurance card(s).
- ❑ A letter of denial if you have been turned down for Medicaid or other insurance.
- ❑ The most current hearing test.
- ❑ A current photo of your child.
- ❑ Your most recent, signed, federal tax form 1040 (If you did not file taxes, please contact us).
- ❑ Your most recent, signed, NC state tax form D-400 (If you did not file taxes, please contact us).
- ❑ The financial eligibility statement, the family portion and the audiology portion of the application.

You can mail or fax your completed application and documents to the address shown on this letter. Upon acceptance into the program, you will be contacted to set up an appointment to see a UNC audiologist and a physician for medical clearance. This visit will only happen once and all of your follow up care will be provided by your local caregivers. Costs for the UNC visits will be covered by the grant program.

Please contact us if you have any questions and thank you again for your interest!

Sincerely,



Holly FB Teagle, AuD

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CCCDP GRANT APPLICATION

Family Portion

Must be filled out completely

Date: _____

Name of Child: _____

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

Street Address: _____

City: _____ State: _____

Zip: _____ County: _____

Phone Number: _____ Email Address: _____

Date of Birth: _____ Place of Birth: _____

Gender: ❑ Male ❑ Female UNC Medical Record Number: _____

Is the child covered by private health insurance? ❑ Yes ❑ No

Is the child covered by secondary health insurance? ❑ Yes ❑ No

Is the child covered by Medicaid or NC Health Choice? ❑ Yes ❑ No

Has the child applied for Medicaid or NC Health Choice and been turned down? ❑ Yes ❑ No

❑ Congenital hearing loss (born with) or ❑ Acquired hearing loss

Age at diagnosis: _____ Age at onset of hearing loss: _____

Etiology (cause) if known: _____

Mode of communication: ❑ Spoken Language ❑ Sign Language ❑ Total Communication ❑ Cued Speech

School: _____

Type: ❑ Home ❑ Residential ❑ Self-contained ❑ Mainstream (❑ fully or ❑ partially)

Date of first hearing aid fitting: _____

Consistency of hearing aid use: ❑ All waking hours ❑ Some waking hours ❑ Never

Where did you hear about the CCCDP grant program? _____

❑ I authorize CCCDP and UNC-Chapel Hill to use pictures, statements, or other documentary evidence of my child's participation in the CCCDP.

❑ I authorize CCCDP and UNC-Chapel Hill to release results of the audiologic and otologic evaluations to the dispensing audiologist.

Parent/Guardian signature: _____

Carolina Children's Communicative Disorders Program Financial Eligibility Statement

For your child to be considered for enrollment in the Program, this statement must be completed in full. This information will be held in confidence. All questions must be answered, the form signed, and your most recent federal tax form 1040 **and** NC state tax form D-400 **SIGNED** and attached.

Patient's name: _____ SSN: _____
Guarantor (person financially responsible for patient): _____
Marital status of guarantor: _____ Guarantor's relationship to patient: _____
Does the patient reside with the guarantor? _____ If not, with whom? _____
Total number of dependents (including guarantor): _____ Names and ages of dependents: _____

Guarantor's employer: _____ Work phone number: _____ How long employed? _____
Employer's address: _____
Spouse's employer: _____ Work phone number: _____ How long employed? _____
Employer's address: _____

INCOME:

	MONTHLY	ANNUAL
Guarantor's Annual Gross Wages		
Spouse's Annual Gross Wages		
Farm or business income		
OTHER INCOME:		
Interest		
Dividends		
Social Security/SSI		
Retirement		
Unemployment Comp.		
Disability		
Child Support Received		
Rental Properties		
Other		
TOTAL GROSS INCOME:		

ASSETS:

Residence: ❑ Rent ❑ Own
Mortgage Balance: _____
Lender: _____
Checking account balance _____
Savings (include Savings and Loan, Credit Union)
Bank Name/Branch
Stocks _____ Bonds _____
IRA/401k _____ Mutual Funds _____
Life insurance _____ Other Assets _____

TAX RETURNS MUST BE SIGNED & MUST INCLUDE FEDERAL 1040 & STATE D-400 FORMS.

IF YOU HAVE NOT FILED TAX RETURNS FOR LAST YEAR, PLEASE CONTACT US!

OTHER ASSETS:	**Description**	**Tax/Market Value**	**Loan Balance**
Real estate other than residence			
Vehicle			
Vehicle			
Farm or business equipment			
Boat/Cycle			

MONTHLY EXPENSES:

$ _____ Mortgage $ _____ Childcare $ _____ Auto Insur $ _____ Property Taxes
$ _____ Rent $ _____ Health Insur. $ _____ Auto Mainten. $ _____ Other

MEDICAL EXPENSES DURING THE LAST 12 MONTHS:

_____
_____

MEDICAL DEBTS:

	Institution	Original Balance	Monthly Payment	Balance Due
1.				
2.				
3.				

I certify that the answers written above are true to the best of my knowledge. I understand that fraudulent or misleading information will make me ineligible for any financial assistance. I authorize the release of any information needed to verify income and assets from my employer and other holders of information.

_____ _____ _____
Signature Date Relationship to Patient

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Dear Audiologist,

Thank you for your participation in the Carolina Children's Communicative Disorders Program (CCCDP). The purpose of the CCCDP is to provide funding for hearing devices for children with hearing loss, whose families do not qualify for other public programs, and who do not have adequate income to obtain devices. Since 1993, the North Carolina General Assembly has provided this grant to assist families in the state who have children with hearing loss.

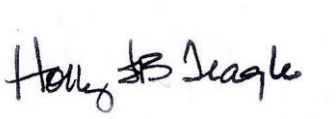
Children enrolled in the grant program must be North Carolina residents under 21 years of age. Acceptance is also based on income, family size, other medical expenses, and the limitations of insurance and other resources. The financial criteria are somewhat flexible so that as many children as possible are served.

Please fill out the audiology portion of this application in its entirety. Generally we are able to pay for mid-level BTE devices that are personal FM compatible. RIC and open fit devices are considered on an individual basis. The grant program also covers earmolds for children who are enrolled in the grant. Please note that while the program pays for hearing devices, it does not pay for loss or damage of the devices. You may charge a fitting fee at your discretion and the family has been informed that they are responsible for these fees.

Upon acceptance into the program, the child will be seen by an audiologist at CCCDP and a UNC physician for medical clearance. Rest assured that this is strictly a program requirement and that patients are instructed to return to their local caregivers for fitting and follow-up. Following the visit with our staff, we will send you instructions on ordering the hearing aids and/or earmolds.

Please contact us if you have any questions and thank you for participating in this program. Your willingness to assist these children is greatly appreciated!

Sincerely,



Holly FB Teagle, AuD
CCCDP Director

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CCCDP GRANT APPLICATION

Fitting Audiologist Portion

Must be filled out completely

Date: _____

Name of Child: _____

Fitting Audiologist Completing Form: _____

Practice Name: _____

Street Address: _____

City: _____ State: _____

Zip: _____ County: _____

Phone Number: _____ Fax Number: _____

Email Address: _____

Degree of hearing loss: Right: ❑ Mild ❑ Moderate ❑ Severe ❑ Profound

Left: ❑ Mild ❑ Moderate ❑ Severe ❑ Profound

Type of hearing loss: Right: ❑ Conductive ❑ Sensorineural ❑ Mixed ❑ Auditory Neuropathy

Left: ❑ Conductive ❑ Sensorineural ❑ Mixed ❑ Auditory Neuropathy

Hearing loss has been: ❑ Stable ❑ Progressive ❑ Fluctuating

Most recent hearing aid fitting date: _____

Currently wearing: ❑ BTE ❑ Open Fit ❑ RIC ❑ CIC ❑ ITE ❑ None ❑ Other_____

Current fit is: ❑ Binaural ❑ Right ear only ❑ Left ear only ❑ CROS

Reason for refit: _____

Make and model of requested device: Right: _____

Left: _____

Please include the child's most recent audiogram with this application.

Please note that the family is responsible for any fitting fees that you charge. The CCCDP does not replace lost or damaged hearing aids.