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

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,

Hannah R. Eskridge, CCC-SLP, LSLS Cert AVT
Director

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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 CCCDP Grant Program, this form must be completed in full. This confidential information will be kept private. It is only used to determine eligibility for the program. All questions must be answered to the best of your ability, and the form signed by an adult (parent or guarantor). ALSO your most recent **Federal Tax Forms IRS 1040 and NC State Tax Form D-400**, must be submitted. If they are long, just send in the first two pages of each. If you have not filed tax returns for last year, please contact us!

Demographics

Child's Name:		DOB:	
UNC Medical Record Number (MRN):		SSN:	
2nd Child's Name:		DOB:	
UNC MRN		SSN:	
Parent #1 Name:		DOB:	
Parent #2 Name:		DOB:	
Street Address:			
City:		State	
Home Phone:		Zip	
Cell Phone(s):			
Email(s):			
Guarantor Name:		Relationship to Child:	
DOB:		Marital status:	
Does the Child live with Guarantor?	Yes:	No:	

Employment

Parent #1 Employer:		How long:	
Job Title:		Phone:	
Parent #2 Employer:		How long:	
Job Title:		Phone:	

Family

Number of persons in household (dependents), including parents:			
Name of sibling #1:		Age:	
Name of sibling #2:		Age:	
Name of sibling #3:		Age:	
Name of sibling #4:		Age:	

Annual Income

Parent #1 Income:	
Parent #2 Income:	
Other annual income (explain):	
Miscellaneous or one-time income (explain):	
TOTAL ANNUAL INCOME:	

Home & Real Estate

Do you own or rent your home?		Own:		Rent:	
Mortgage balance:		Lender:			
Do you own other real estate		Yes:		No:	
If Yes, describe:					

Annual Expenses

Rent or mortgage (monthly_____X12):	
Utilities (power, water, internet, phones):	
Vehicle maintenance and fees per year	
Medical expenses (in last year):	
Medical debt payment (____ X 12)	
Medical Debt balance still owed	

Medical Insurance

Medical insurance (premiums per year):							
Medical insurance deductible per year:							
Name of Company:							
Subscriber Name:						DOB:	
Is Child covered?	Yes:		No:		Ins. ID#:		

Comments (Any other information that you would like to provide about financial need.)

Signature:		Date:	

By signing this form you certify that the answers provided above are true to the best of your knowledge. You also understand that fraudulent or misleading information will make you ineligible for any financial assistance. We reserve the right to contact your employer or other holders of financial information.

Carolina Children's Communicative Disorders Program (CCCDP),5501 Fortunes Ridge Dr., Suite A,Durham, NC 27713
Velma.Grose@unchealth.unc.edu;919-419-1449 (Phone) 919-419-1399 (Fax); Website: www.ChildrensCICenter.com

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Dear NC 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!

Hannah R. Eskridge, CCC-SLP, LSLS Cert AVT
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.