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,

Erika B Gagnon

Erika B. Gagnon, AUD
Program Director, CCCDP

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CCCDP GRANT APPLICATION

Family Portion

Must be filled out completely

Date: _____

Name of Child: _____
Name of Parents/Guardian: _____
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

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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

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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 grant program.

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

Parent/Guardian signature: _____

Financial Eligibility Statement

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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 (if 2nd child is also hearing impaired): _____ DOB: _____
UNC Medical Record Number (MRN): _____ SSN: _____
Parent #1 Name: _____ DOB: _____
Parent #2 Name: _____ DOB: _____
Street Address: _____
City: _____ State: _____ Zip: _____
Home Phone: _____ Cell Phone(s): _____
Email Address(es): _____
Guarantor Name: _____ DOB: _____
Guarantor Marital Status: _____ Does the child live with the 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: _____

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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 _____ x 12) Total: _____
Utilities (power, water, internet, phones): _____
Vehicle maintenance and fees per year: _____
Medical expenses (in last year): _____
Medical debt payment (_____ x 12) Total: _____
Medical debt balance still owed: _____

Medical Insurance

Medical insurance premiums per year: _____
Medical insurance deductible per year: Indiv: _____Family max:_____
Name of Company: _____
Subscriber Name: _____Group number_____
Is child covered? Yes No Policy Number (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.

Please direct all questions related to this application to
CCCDP Program Director at cccdpgrant@unchealth.unc.edu
Phone: (919) 419-1449; Fax: 919-419-1399

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****** Please share this letter and the following for with your local audiologist complete. Return the 'Audiologist Portion' with your completed CCCDP grant application ******

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 ear molds 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 ear molds.

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,

Erika B Gagnon

Erika B. Gagnon, AUD
Program Director, CCCDP

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CCCDP GRANT APPLICATION

Audiologist Portion

Must be filled out completely

Date: _____

Name of Child: _____DOB: _____
Name of Fitting Audiologist: _____
Name of Practice: _____
Street Address: _____
City: _____ State: _____ Zip: _____County: _____
Phone Number: _____ Email Address: _____
FAX Number: _____

Degree of Hearing Loss _____ Right: Mild Moderate Severe Profound
Left: Mild Moderate Severe Profound
Type of Hearing Loss _____ Right: Sensorineural Conductive Mixed
Left: Sensorineural Conductive Mixed
Hearing loss has been: Stable Progressive Fluctuating

Most recent hearing aid fitting date: _____
Currently wearing BTE Open fit RIC ITE CIC None
Current fit is Bilateral Unilateral CROS or BiCROS
Reason for refit _____
Make and model of requested device: Right _____
Left _____

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

Audiologist signature: _____

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