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). This program provides funding for hearing aids and/or cochlear implant speech processor maintenance for children with hearing loss whose families do not qualify for other public programs, and who do not have adequate income to obtain or maintain 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 note that while the program pays for repairs on cochlear implant speech processors that are out-of -warranty, batteries and replacement parts needed to keep your child hearing, it does not cover the cost of accessories such as streaming devices, remote microphone technology (Roger), waterproofing covers and the like. It does not pay for loss or damage of the devices. Support for processor upgrades (with up to a $5000 out-of-pocket expense to the family per ear) are considered on an as needed basis.

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
- 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 notified by mail. In the event that your child requires a repair on their speech processor or replacement parts, you will need to contact your CI audiologist so they may order the needed parts from your CI manufacturer and bill them to the grant program. Costs for CI mapping appointments and ENT follow-up 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