

CNI CENTER FOR HEARING'S COCHLEAR IMPLANT ASSISTANCE PROGRAM

ONLY COMPLETE APPLICATIONS WILL BE CONSIDERED

Information that you provide will be kept strictly confidential. If your application is selected for funding, the resulting transaction, and any claim or dispute arising out of such transaction, shall be governed by the laws of the State of Colorado.

APPLICANT/FAMILY INFORMATION

Date: _____

Name of Applicant (patient for whom the Cochlear Implant is being requested):

Gender M _____ F _____ Date of Birth: _____

Address (Street/City/State/Zip/Phone):

Phone

Email address of applicant (of parents, if applicant is a minor): _____

Applicant's Social Security Number: _____

Mother's Name: (if applicant is a minor) _____

Address/Phone: _____

Father's Name: (if applicant is a minor) _____

Address/Phone: _____

Names and Ages of Dependents or Siblings (if applicant is a minor):

Relationship & Name of Person Completing Application: _____

DEVICE REQUESTED

If there is a preference for a specific cochlear implant manufacturer, please indicate: _____

Please state why assistance is needed: _____

What other sources of assistance have you sought or have been offered (foundations, fund-raisers, employee assistance funds, etc) and what is the result? _____

CANDIDACY

Has the applicant been approved as a candidate by a Cochlear Implant Center? Yes ___ No ___
(candidates must be evaluated prior to being considered for the Cochlear Implant Assistance Program)

Center Name/City/State _____

Cochlear Implant Surgeon _____

Cochlear Implant Team Coordinator – Name & Phone _____

EDUCATIONAL HISTORY (if applicant is a minor)

School Attending _____ Primary Teacher _____

Address (City/State/Phone): _____

Type of Communication: Oral ___ Sign ___ Total Communication ___

Additional Therapy or Rehabilitation Programs _____

HEALTH INSURANCE

Is the applicant covered under any Health Insurance plan (private or government)? Yes ___ No ___

Policy Holder: _____ Identification No. _____ Group No. _____

Name of Insurance _____ Phone _____

Address _____

Has coverage been denied for the requested products and/or services? Yes ___ No ___

If health insurance has denied coverage, has an appeal been filed? Yes ___ No ___

If an appeal has been filed, what is the result of that filing? (please attach all correspondence)

Does the applicant have Medicaid or Medicare Coverage (Part B)? Yes ___ No ___

If no, has an application for Medicaid or Medicare Coverage Part B been submitted? Yes ___ No ___

If yes, what was the result? (Please attach all correspondence to or from Medicaid/Medicare)

INCOME

Name of Employer (of adult applicant and/or spouse/partner – provide information for all household members):

Address: _____

Phone: _____ Years/Months of employment with employer*: _____

Spouse's/Partner's Employer & Annual Salary/Wages _____

Father's Employer & Annual Salary/Wages (if applicant is a minor): _____

Employer's Address & Phone: _____

Years/months of employment with employer*: _____

Mother's Employer & Annual Salary Wages (if applicant is a minor): _____

Employer's Address & Phone: _____

Years/months of employment with employer*: _____

*If employment is less than 2 years, please attach information for each employer of the past 3 years)

If applicant or either parent is not currently employed, please provide explanation:

Is the applicant receiving SSI/SSD (Supplemental Security Income/Social Security Disability)? Yes___ No___

If yes, when did benefits begin? (provide the date) _____

If no, has an application been submitted? Yes___ No___ What were the results? _____

(Please attach any correspondence to or from Social Security Administration office)

Combined Yearly Household Income of Applicant (and/or Spouse/Partner) or Both Parents (if applicant is a minor): _____

Identify all income sources and amounts (i.e., salary, social security, military, alimony, child support, real estate, rental income, dividends from stocks/bonds, etc.)

a. _____ Monthly amount: _____

b. _____ Monthly amount: _____

c. _____ Monthly amount: _____

Checking Account Balance: \$_____ Name of Bank _____

Savings Account Balance: \$_____ Name of Bank _____

Year and Make of Automobile(s) _____ Loan Balance _____

Year and Make of Automobile(s) _____ Loan Balance _____

Stocks/Bonds/401(k) _____

House/Property Value _____ Loan Balance _____ Equity Amount _____

Other assets (please list with current market value – use separate sheet, if needed)

EXPENSES (monthly)

Rent/Mortgage _____ Water/Sewer _____ Food _____
Public Service _____ Telephone _____ Clothing _____
Auto Payments _____ Pharmacy _____ Gas/Oil _____
Auto Insurance _____ Medical _____ Dental _____
Life Insurance _____ Health Insurance _____

Creditor / Monthly Payment / Current Balance / Item or Service Purchased

Other expenses: _____

PERSONAL STATEMENT

To be written by applicant - if applicant is between 13-18 years old, both the applicant and a parent should write separate statements. If applicant is less than 13 years of age, a statement from a parent is sufficient.

Please state how you think the cochlear implant will improve/enhance the life of the applicant socially, educationally, professionally, etc. You may use extra paper, if needed.

What are the expectations for the change in the applicant's hearing ability?

Relationship to applicant & name of person who wrote Personal Statement _____

RELEASE & VERIFICATION OF INFORMATION / UNDERSTANDING OF TERMS

I understand that the information submitted to CNI concerning annual income, family size, family assets, insurance, and medical history are subject to verification by CNI or their agents. I also understand that if the information I submit is found to be false, such a determination will result in elimination of my name from consideration for assistance. I further understand that the supply of cochlear implants for this program is limited and that the CNI Center for Hearing's Cochlear Implant Assistance Program will submit a request to the manufacturer for an implant only if this application is approved following the review process. Availability of the cochlear implant will then be determined at the discretion of the manufacturer.

I further understand that, if I am approved via the Cochlear Implant Assistance Program, CNI will provide only the implant system itself and will not be responsible for any other fees associated with the cochlear implant procedure. I understand that I will be solely responsible for the payment of these expenses which may include, but may not be limited to, the surgeon's, audiologist's, anesthesiologist's, and hospital's fees. I further understand that there will be ongoing expenses associated with the maintenance and performance of my cochlear implant and, by signing below, I am indicating my commitment to accept and manage those expenses.

Applicant's Printed Name: _____

Signature (of Applicant or Parent): _____

Social Security Number: _____ Date: _____

Spouse's/Partner's Printed Name: _____

Signature of Spouse/Partner: _____

Social Security Number: _____ Date: _____

Father's Printed Name (if applicant is a minor): _____

Signature: _____

Social Security Number: _____ Date: _____

Mother's Printed Name (if applicant is a minor): _____

Signature: _____

Social Security Number: _____ Date: _____

MEDIA RELEASE (This section is voluntary and will not impact consideration for assistance.)

If requested, I agree to allow CNI to utilize video footage, photographs and/or our personal story regarding the cochlear implant process in publications or for media release at the discretion of CNI.

Printed Name: _____

Signature: _____

Date: _____

AUTHORIZATION TO RELEASE/REQUEST RECORDS/INFORMATION
(to be completed by patient or parent/guardian)

I authorize the Colorado Neurological Institute (501 c 3) Center for Hearing's Cochlear Implant Assistance Program to release/request records/information to/from the following as it pertains to my request to obtain a cochlear implant. My signature releases CNI to view and process all confidential medical information, after which time such information will then be retained/filed/destroyed according to CNI policy.

Cochlear Implant Team Coordinator: _____
Facility Name: _____
Phone: _____
Fax: _____
Email: _____

Primary Care or ENT Specialist: _____
Phone: _____
Fax: _____

Cochlear Implant Surgeon/Practice: _____
Phone: _____
Fax: _____

Audiologist/Facility: _____
Phone: _____
Fax: _____

Hospital/Surgical Center & Name of Contact Person: _____
Phone: _____
Fax: _____

Other (Parent, Friend, Other – Please Specify): _____
Phone: _____
Fax: _____

Patient Name _____

Person authorized to sign for patient

Signature _____

Signature _____

Printed Name _____

Printed Name _____

Date of Birth _____

Relationship to Patient _____

Date _____

Date _____

Colorado Neurological Institute (CNI)

Center for Hearing
Cochlear Implant Assistance Program

Statement of Agreement

(to be completed by Implant Surgeon)

In accordance with the mission of the CNI Cochlear Implant Assistance Program, I agree that the no-charge cochlear implant system (internal component and speech processor), for which _____ (**patient's name**) is being considered as a donation recipient, will be used for no other patient and will not be retained nor sold nor given to any individual or organization for any other purpose.

I agree that the aforementioned patient will not receive any invoice nor will payment of any kind be required of the patient, or patient's family in the case of a minor, or any insurance carrier, for the cochlear implant system itself. I understand that this agreement pertains only to the implant system hardware itself and does not necessarily reflect any financial arrangement regarding other fees including, but not limited to, surgeon's, audiologist's, hospital's, anesthesiologist's, or laboratory's fees associated with the cochlear implantation procedure. In accordance with the CNI Cochlear Implant Assistance Program's mission, I agree that attempts will be made to have associated fees waived or reduced, and that, in any case, the associated fees shall not exceed the average rates of reimbursement as paid by Medicare.

If the CNI Cochlear Implant Assistance Program agrees to award a no-charge implant system to the aforementioned patient, I agree that I will provide the scheduled surgery date information to the CNI Cochlear Implant Assistance Program not less than 21 days before the scheduled date and further agree that I will contact the program within 72 hours following the scheduled date of surgery to confirm the status of the procedure. If the surgery does not take place as scheduled, I agree that I will contact the CNI Cochlear Implant Assistance Program with that information, as stated above, and will then provide updates at intervals not to exceed 7 days regarding the delay and/or re-scheduling.

I agree to comply with the CNI Cochlear Implant Assistance Program and the device manufacturer's instructions in returning the donated implant system in its entirety, if the surgery of the aforementioned patient is cancelled or significantly delayed, at the discretion and request of the CNI Cochlear Implant Assistance Program.

I have reviewed the patient's current insurance coverage (if any) and have confirmed that no portion of the cochlear implant procedure, nor the equipment itself is covered under his/her plan.

I agree that any claim or dispute arising out of the CNI Cochlear Implant Assistance Program shall be governed by the laws of the State of Colorado.

Signature of implant center representative

Printed name of implant center representative

Date

Telephone

Email

COLORADO
NEUROLOGICAL
INSTITUTE

CNI
CENTER FOR HEARING



- > Rocky Mountain Cochlear Implant Cent
- > CNI Cochlear Kids Camp
- > Cochlear Implant Assistan Program
- > Angel Network
- > World Hearing Network
- > Mile-Hi Sertoma Club MicroSurgical Teaching Lal

Medical Dire
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jstucky@TheCNI.org email
www.TheCNI.org/hearing websit

Name of Candidate: _____

REQUIRED ATTACHMENTS (photocopies may be submitted if originals are not available)

Document Type:	Must Include:
A. Proof of Permanent, Legal US Residence	1. Birth Certificate OR United States Passport OR Certificate of Naturalization (Form N550) OR a Green Card (Resident Alien Card). Note – If applicant is a minor, parent(s) must submit proof for self(selves) as well as for the child
B. Income/Benefits	1. Signed, dated copy of previous year’s tax return 2. Past 3 months’ paycheck stubs or statement of social security/welfare payments of applicant and/or spouse/partner, or parent(s) if applicant is a minor
C. Insurance Documents	1. Copy of front/back of insurance card of applicant 2. Complete insurance benefit booklet 3. Copies of all appeal and denial correspondence to/from insurance company – two documented denials/appeals are required
D. Auth. to Release / Request Information	1. Completed, signed Authorization to Release/Request Information (application attachment)
E. Summary of Patient’s/Family’s Out-of-Pocket Costs (excluding the cochlear implant system itself)	1. Complete list from implant center of all costs associated with procedure for which the applicant will be responsible; it is the expectation of the Cochlear Implant Assistance Program that the charges, including the surgeon’s, audiologist’s, anesthesiologist’s and facility’s fees, will not exceed the average reimbursement as paid by Medicare
F. Implant Audiologist’s Summary (date of testing must be within the last 12 months)	1. Audiogram Unaided threshold & perception Aided: Adult – HINT Sentences Children – LNT Scores OR Infants – ABR & OAE
	2. Etiology, type, onset & duration of deafness
	3. Hearing Aid History – when aided, model/type of aids, working status, consistency of use, benefit of aids
	4. Overall impression of candidate as CI user (include summary of patient’s/family’s expectations of results, any counseling regarding those expectations, motivation/commitment to rehab, etc)
G. Surgeon’s Medical Summary (date of testing and assessment must be within the last 12 months)	1. Ear health/history 2. General medical history 3. Overall impression of candidate as CI user (include summary of physician’s expectations of results, a statement summarizing a review of treatment options for the patient and a statement of summary regarding the patient’s/family’s insurance coverage) 4. CT Scan/MRI results (may be summarized as text in the letter) 5. Signed Statement of Agreement (application attachment)

**Please return completed form to:
CNI Cochlear Implant Assistance Program
701 E. Hampden Ave. #330
Englewood, CO 80113**

**Please ensure that all copies of the required documents are sent with the original application.
Please keep a copy of all submitted documents for your own records.**

Incomplete applications will not be considered. Applicants will be contacted if incomplete applications are received and will be given a maximum of 6 months during which all required documents must be submitted and received. Failure to provide all materials within 6 months will result in the application being classified as inactive and destroyed. If an applicant later wishes to be reinstated for consideration, all paperwork must be re-submitted under the guidelines in place at that time.

Applications are reviewed every 6 months and may be updated more frequently as needed. Effective date – 01/06