

CNI CENTER FOR HEARING'S ANGEL NETWORK APPLICATION

ONLY COMPLETE APPLICATIONS FROM LEGAL COLORADO & WYOMING RESIDENTS 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 rehabilitation assistance is being requested):

Gender M _____ F _____ Date of Birth: _____

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

Email address of applicant (or 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: _____

ASSISTANCE REQUESTED

Type of Assistance: Auditory/Verbal _____ Speech Therapy _____ Other _____

Number of sessions per week or month for which Angel Network assistance is requested: _____

Please state why assistance is needed to cover some or all of the costs of auditory/verbal rehabilitation:

Date of cochlear implant surgery _____ Name of surgeon _____

Type of cochlear implant (device manufacturer) _____

CANDIDACY

Is the applicant currently receiving speech/language therapy? Yes ___ No ___

If yes: Therapist - Name _____ Phone _____ Email _____

Therapy Center Name _____

Address _____

(If needed, list additional therapists on a separate sheet of paper and attach to this application.)

EDUCATIONAL HISTORY (if applicant is a minor)

School Attending _____ Primary Teacher _____

Address (City/State/Phone): _____

Type of Communication Mode 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 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 been submitted for Medicaid or Medicare Coverage Part B? Yes ___ No ___

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

INCOME

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

Yes ___ No ___

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

If no, has an application been submitted? Yes ___ No ___ What were the results? _____
(Please attach any correspondence to/from Social Security Administration office)

Name of Employer (if applicant is an adult):

Address: _____

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

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

Employer's Address & Phone: _____

Years/months of employment with employer*: _____

Mother's Employer (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 5 years)

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

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

Identify all other income sources and amounts (i.e., social security, military, child support, real estate, rental income, etc.)

- a. _____ Monthly amount: _____
- b. _____ Monthly amount: _____
- c. _____ Monthly amount: _____

List additional sources on separate sheet of paper, if needed.

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 _____

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

Stocks/Bonds (do not include 401(k)/IRA investments) _____

Other assets (please list with current market and/or mortgage value)

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

Other expenses: _____

PERSONAL STATEMENT

To be written by applicant (If applicant is between 13-186 years of age, both the applicant and a parent should write separate statements. If applicant is less than 13, a statement written by a parent is sufficient.)

Please state how rehabilitation therapy will improve/enhance the life of the applicant: educationally, socially, etc. Use extra paper, if needed.

What are the expectations for the change in hearing/language/communication ability?

Name of person who wrote Personal Statement & relationship to applicant: _____

RELEASE & VERIFICATION OF INFORMATION

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 funds available for this program are limited and that the CNI Center for Hearing's Angel Network will submit a request to the fund administrator only if this application is approved following the review process. Awarding of funds will then be determined based upon availability.

Applicant's Printed Name: _____

Signature: _____

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: _____

Name of Candidate: _____

REQUIRED ATTACHMENTS

Document Type	Include	Date Sent / Recd
1. Proof of Legal Residence in Colorado or Wyoming	1. Copy of Birth certificates, Passports or Certificates of Naturalization for applicant; if applicant is a minor, proof of parent(s) is also required	
2. Income	1. Copy of signed, dated, complete tax return from previous year	
	2. Copies of pay stubs from all household earners for past 3 months or 3 months' of social security/welfare payments/statements showing benefits	
3. Letter from certified/licensed Auditory/Verbal or Speech Therapist(s) - Please submit one letter from each therapist associated with the patient	1. Date therapy began (or is scheduled to begin)	
	2. Progress of therapy to date	
	3. Planned frequency and duration of therapy	
	4. Cost per session	
	5. Other funding sources/foundations/grants/etc currently being accessed for this patient	
	6. Other funding sources/foundations/grants/etc available to this patient to which patient has applied or to which the patient could apply	
	8. Overall impression of candidate as CI user	
4. Insurance Documents	1. Photocopy of front & back of insurance card	
	2. Copy of complete benefit booklet	
	3. Copies of correspondence regarding Denial of Coverage; 2 letters each of appeal & denial are required	

**Please return completed form to:
CNI Angel Network
701 E. Hampden Ave. #330
Englewood, CO 80113**

Please ensure that all copies of required documents are sent with original application.

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