COCHLEAR IMPLANT APPLICATION FORM
South Dakota Department of Human Services
Division of Rehabilitation Services

Date: ____________________

Personal Information

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

First Name: ___________________________MI______ Last Name: _________________________________

SS#:_________________________ Birth date: ______________________ Gender: Male____ Female____

Age at Application: ______ if over the age of 5, at what age did applicant encounter hearing loss? _______
(If over the age of 5, applicant must provide documented hearing loss that led to deafness after speech and language were developed)

Does the applicant currently have one implant? Yes____ No____

If yes, at what age did the applicant receive the first implant? __________________

Mother's (Guardian's) Name: ____

Address / Phone: ____

____

Father's (Guardian's) Name: ____

Address / Phone: ____

____

Relationship & Name of Person Completing Application: ____

Medical Candidacy

Has the applicant been approved and medically recommended as a candidate by a Cochlear Implant surgeon? Yes____ No____ Is the applicant receiving one or two implants? _____________
(*Candidates must be evaluated prior to being considered for the Cochlear Implant Program*)

Center Name / City / State ____

____

Cochlear Implant Surgeon ____

Cochlear Implant Team Coordinator Name & Phone ____

Health Insurance

Is the applicant covered under any Health Insurance Plan? Yes _______ No __________

Policy Holder: __________________Identification No. __________________Group No. _______________

Name of Insurance: ____Phone:______________________

Address: ____

Has coverage been approved for the requested services? Yes ____ No ____
(If coverage has been approved, please provide documentation pertaining to out of pocket expenses such as deductibles, co-payments, and coverage limits)

Has coverage been denied for the requested services? Yes ____ No ____
(*If coverage has been denied, please provide documentation pertaining to this denial including reason for denial*)

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 relevant correspondence)?

Does the applicant have Medicaid Coverage? Yes ____ No ____

If yes, what was the result? (*Please attach relevant correspondence to or from Medicaid*)

Expenses not covered or not payable for some reason other than the deductible and coinsurance provisions in the health insurance plan are not eligible.

> →*No amounts are payable by the telecommunication fund for the deaf for any portion of the cost of covered services listed in 46:30:08:03 covered by a health insurance plan or otherwise covered under another plan of insurance. The telecommunication fund for the deaf shall be secondary to any other insurance covering or providing reimbursement for the cochlear implant surgery, device, initial mapping and follow-up mapping.*

I declare and affirm that the information included in this application and additional information as required by the cochlear implant program is true and correct to the best of my knowledge and ability. I also acknowledge it is my responsibility to report any significant changes that could affect eligibility for the Cochlear Implant Program.

Parent or Guardian's Signature: ____
Date: ______________________

Submit application to:
Shayna Ebben
Division of Rehabilitation Services
1310 Main Ave S Ste. 107A
Brookings, SD 57006

Please submit certification of hearing loss and estimated costs along with this application