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:
Katie Gran
Division of Rehabilitation Services
811 E 10th St Dept 21
Sioux Falls, SD 57103

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