

**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:**  
Janet Ball  
Division of Rehabilitation Services  
Hillsview Properties Plaza  
c/o 500 E Capitol  
Pierre, SD 57501

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