Telecommunications Access Program

A Program of the Department of Career Education
Arkansas Rehabilitation Services Division
PO Box 3781, Little Rock, Arkansas 72203

1-800-981-4463 (V/TTY)
FAX 501-683-3011
www.ace.arkansas.gov

Will Be Seen by Appointment Only
APPLICATION

Section 1 – to be completed by the applicant (Please type or print clearly)

I am a resident of Arkansas: _____**YES**_____**NO**

I have phone service or personal telecommunication service and/or will have service within 30 days: _____**YES**_____**NO** (You may be asked for further documentation before receiving equipment)
(Caution: Equipment may or may not work with digital, cable or satellite and/or may damage equipment)

Last Name: _____ First Name: _____MI:_____

Street Address: _____City:_____

State: _____ Zip Code: _____ County: _____

Mailing Address (if different from street address)
_____

Social Security Number (Last four digits): __ __ __ __

Male_____Female_____Birthdate_____/_____/_____

Home Phone Number ( ) __ __ __ - __ __ __ __ (V/TTY/VP)

Name of phone company/provider_____

Do you have high speed internet or DSL? ____**YES**___**NO**

Do you have caller ID service? ____**YES**____**NO**, if marked yes, do you want a phone with Caller ID capabilities? ____**YES**____**NO**

Email Address: _____

Your mode of communication: Sign Language____ Speech_____ Written_____

Nationality: Caucasian____ African American____Hispanic_____Asian_____
Native American____ Other_____

Please provide an additional contact person (someone living at a different address)
Name_____Address_____

Phone Number_____Relationship to you_____

Have you applied for TAP equipment in the past? ___**YES**___**NO** If yes, when?____
(Reapplication required every 3 years if asking for other equipment or sooner if TAP requests updated information.
Are you an Arkansas Rehabilitation Services' client? ____**YES**____**NO**

Income Information:
Total number of family members living in household: _____

Annual gross income of the applicant: $_____per year

Source of Income: _____ (If your income is over $50,000 a year, the equipment may be provided for one third of the item's cost to the program).

How did you learn about TAP?
Newspaper/TV_____Audiologist/Doctor_____Friend/Family_____Presentation____
Health Fair_____Website_____ARS Staff_____
Other (please explain) _____

Equipment Available: (Please Check Only One)

Following are examples of equipment available. Please check the equipment you are requesting. TAP staff may assist you in finding equipment that meets your needs.

Do you need training? ____YES_____NO

□ **Amplified Phone:** Allows a hard of hearing user to increase the volume and adjust the tone of the incoming voice.

□ **Amplified Phone with Speakerphone**

□ **Cordless Amplified Phone**

□ **Captioned Telephone (CapTel):** Captioned telephone that allows a severely hard of hearing user to speak for themselves and read incoming text through a captioning service.

□ **Hands Free Telephone:** Allows a mobility impaired individual independent communication through the use of a remote control speaker phone with optional headset and/or other special features.

□ **Phones Compatible with Augmentative Communication Devices:** Allows speech and/or mobility impaired users a means to use their device with a compatible phone.

□ **Amplified Telephone with Talking Keypad:** Allows a blind or low vision user to hear the numbers on the keypad as they are pressed.

□ **Amplified Telephone with Talking Keypad and Talking Caller ID:** Allows a blind or low vision user to hear the numbers on the keypad and the phone number of the caller.

□ **Cordless Amplified Telephone with Talking Keypad and Talking Caller ID**

□ **Hearing Carry-Over Phone:** Allows speech impaired individuals to communicate by using a combination text telephone and standard phone through the relay service.

□ **Electrolarynx:** Handheld, portable voice aid which allows people who have lost use of their larynx a means to communicate. (Specific electrolarynx must be recommended by the person
who signs the Eligibility Certification)

□ **Speech Amplifier:** Allows a speech impaired user with low speech to amplify

their outgoing voice.

□ **TTY:** Allows a deaf user to send and receive typed messages.

□ **TTY with Braille:** Allows deaf-blind individuals to send and receive Braille messages.

□ **TTY or Q90 with Large Visual Display:** Allows deaf users with severe low vision to send and receive typed messages on a large screen.

□ **DeafBlind Communicator:** Allows deaf-blind individuals that can read Braille a means to communicate.

□ **Photo Phone:** Telephone with photo auto-dial memory buttons that allows easier dialing for someone with cognitive impairments.

□ **Wired Amplifying Cellular Loopset:**
Allows T-coil equipped hearing aid users to receive amplification on a cell phone through the use of a cable.

□ **Wireless Bluetooth Amplifying Cellular Loopset/Headset:** Allows either T-coil equipped hearing aid users or non-T-coil/non-hearing aid users to receive amplification on a cell phone. Must have a Bluetooth option on your cell phone.

□ **Jitterbug cell phone:** The Jitterbug J has big buttons and a large bright screen, so it's easier to see for those with low vision. It also has a padded earpiece that helps keep unwanted noises out to help you hear conversations more clearly. There is a short separate application to fill out if you are requesting the jitterbug. Please contact our office and we will send it to you or you can go online at www.ace.arkansas.gov and download it. (Network provider for the Jitterbug is through Verizon.)

□ **Wireless (cellular) Phone:** We offer a variety of cell phones meeting all disability needs. You may view available cell phones through TAP at www.pcsorders.com/tapar or you can contact our office for more information. **You may not order any equipment from this website until you have filled out this application and been approved by TAP. The service provider is Sprint.**

Signaling Devices

If you need a device to alert you when the phone rings please check **one** of the choices below**:**

□ **Audible Ringer:** Loud ringer that alerts a hard of hearing person that the phone is ringing.

□ **Visual Signaler:** A flashing light that connects to a lamp which flashes on and off when the phone rings to alert a deaf or severely hard of hearing individual that the phone is ringing.

□ **Combination Signaler:** A combination strobe light and loud ringer that alerts a hard of hearing person that the phone is ringing.

□ **Tactile Ringer:** A vibrating ringer that alerts a deaf-blind individual that the phone is ringing.

_____

By signing this application I understand and accept the conditions of acceptance (page 5) and certify that the information I have given is true.

Signature of Applicant

_____Date_____

Note: If the applicant is a minor (under 18), then a parent or legal guardian must sign.

Mail Section 1 and 2 of this application back to: TAP, PO Box 3781, Little Rock, AR 72203

Section 2 – Eligibility Certification (to be completed by the certifier) Take this form to one of the professionals listed below.

Applicant's name: _____ Date of Birth: _____

To be eligible for certification for this program, the applicant must meet the criteria as defined below. Check all that apply.
_____ Deaf: A hearing loss of such severity that requires use of a TTY or other specialized equipment.
_____ Deaf-Blind: A hearing loss accompanied with vision loss that prohibits use of a standard telephone and TTY.
_____ Hard of Hearing: A hearing loss that requires use of an amplified telephone or other specialized equipment.
_____ Mobility Impairment: A physical upper and/or lower extremity impairment which prohibits use of a standard telephone.
_____ Cognitive Impairment: Impaired ability to dial a series of numbers, to access (or memorize) a list of phone numbers or to use the phone to get emergency services.
_____ Legally Blind/Low Vision: A visual loss so severe that the individual relies on larger than standard size buttons, audible or Braille information.
_____Speech or Voice Impairment: Inability to speak intelligibly or use adequate voice on a standard phone. (If an Electrolarynx is requested, the specific recommendation from the certifying professional must be included.)
Specify which electrolarynx: _____

Description of disability and limitations: _____
_____
_____

I am qualified to certify eligibility as (**Check one**)

Physician____
Audiologist_____
Speech Pathologist____
Occupational Therapist_____
Physical Therapist_____
Neuropsychologist_____
Arkansas Rehabilitation Services qualified staff_____
Social Worker____
Case Manager____
Ophthalmologist_____
Optometrist_____
Arkansas School for the Deaf qualified staff_____
Division of Services for the Blind Counselor_____
Arkansas Spinal Cord Commission Counselor_____
Home Health Professional_____
Nurse_____
Hearing Aid Dealer/Specialist_____

I certify the above-named person meets the requirements of having a disability which limits or prohibits the use of the telecommunications network without specialized equipment. I also certify that use of equipment for their disability should benefit this person.

Signature of Certifier_____Date_____

Print Name_____Title_____
Street_____City_____State____ Zip_____

Telephone_____License Number (if applicable) _____
Fax Number_____

Keep this page for your records.

Conditions of Acceptance:

If you receive equipment from this program, the following conditions will apply:

1. I understand that the equipment remains the property of the state of Arkansas for two (2) years and then becomes my property. If I abuse the equipment during these two years, I can be held financially responsible for the replacement, repairs and shipping costs.

2. I will cooperate and comply with inventory/follow up requests.

3. I may exchange equipment if:
   a) It is stolen, damaged through natural disaster, or damaged by something out of my control. (A police or fire report must be sent to TAP)
   b) It no longer meets my needs due to a change in my disability. (New certification may be required and sent to TAP)
   c) It does not work (broken) or cannot be repaired due to normal wear and tear. (Individual must still be approved by TAP and re-application may be necessary after the two year time period).

4. I understand the equipment I receive today must be returned to TAP within 30 days if:
   a) I move to another state.
   b) I no longer need or want the equipment.
   c) I no longer have phone service.
   d) I move to a facility where I no longer have personal phone service.

5. I understand I need to contact TAP at 1-800-981-4463 (V/TTY) if:
   a) My address or phone number changes.
   b) I will be out of state more than 90 days with my equipment.
   c) Death occurs in the first two years after receipt of equipment, executor or other responsible person should contact TAP to make arrangements for possible return of the equipment if applicable or supply appropriate information to complete transfer of equipment to another eligible individual (including, but not limited to, certification of disability).

6. If my equipment stops working, I will not try to fix it but will contact TAP at 1-800-981-4463 (V/TTY) for instructions as to what I need to do.

7. I understand that I cannot sell, give away, pawn or loan this equipment to anyone else. This could result in suspension from TAP for four (4) years from the date TAP was made aware that I broke the rules.

8. I am responsible for all extra materials including batteries, light bulbs, electrolarynx accessories and other miscellaneous supplies.

9. I am responsible for keeping the equipment clean and protected (away from rain, heat, bugs, pets, liquid, sticky/greasy substances and excessive smoke from tobacco use).

10. I understand that this agreement is binding for any additional or exchanged equipment that I receive from the program.

11. I understand it against State law to file any false statements regarding my application, income, theft, loss or damage to the equipment. Failure to comply with the conditions of acceptance may result in me being denied participation in the equipment program.

Keep this page for your records.

Your Rights:

Fair Treatment
Arkansas Rehabilitation Services is in compliance with Titles VI and VII of the Civil Rights Act, the Americans with Disabilities Act and is operated, managed and delivers services without regard to age, religion, disability, sex, race, color or national origin.

Confidentiality
All Applicant information will be kept confidential except for approved release of information for a specified purpose. The requested information is voluntary; however, failure to provide information may result in delay or denial of services. The purpose and need for such information is to establish eligibility for the TAP Authority: Act 501 of 1995.

How to Appeal
You have the right to appeal if you do not agree with our action or you feel that TAP did not act on your request for services. To appeal contact the ARS Commissioner's Office in writing at: ARS, 525 W. Capitol, Little Rock, AR 72201 or call 1-800-330-0632 (V/TTY).

Need to contact us?

Voice/TTY 1-800-981-4463
Voice/TTY 501-686-9693
VP 501-246-8219
Fax 501-683-3011
Office Hours: Monday - Friday: 8:00 - 4:30 (**Will be seen by appointment only)**