

INSTRUCTIONS

- I. Complete Part I of the form (see pages 3-4, Application for an Assistive Telecommunications Device). A parent or legal guardian must sign the form if the applicant is under 18 years of age.

- II. Have Part II of the application completed and signed by a certified professional (see page 5, Certification of Impairment).
 - A. Who is a Certified Professional?
 1. **Medical Doctor** - Any person permitted to practice medicine in the State of Utah.
 2. **An Audiologist** . A person who has a Masters or Doctoral degree in Audiology and a Certificate of Clinical Competence in Audiology issued by the American Speech, Language, and Hearing Association.
 3. **A Speech Pathologist** . A person who has a Masters or Doctoral degree in Speech/Language Pathology and a Certificate of Clinical Competence issued by the American Speech, Language, and Hearing Association.
 4. **A qualified state agency employee** . Any state agency employee which serves the applicant in a Human Service Program capacity and can obtain professional documentation of the disability.

III. **Mail in form to:** **Equipment Distribution Program
C/O The Utah Public Service Commission
160 East 300 South, Box 45585
Salt Lake City, UT 84145-0585**

Upon receiving the application form, the applicant will be notified in writing or by phone regarding the status of their request for an assistive device. If approved, the applicant will be notified how device will be received. Applicants must be able to use the equipment they receive. If the applicant is unable, then the applicant must receive training in order to sign for the device.

WHO QUALIFIES?

- I. The Equipment Distribution Program of the Public Service Commission is a program designed to meet the telecommunication needs of the Deaf and Hard of Hearing in Utah. The individual must meet one (A and/or B) of the following two conditions. If you have any questions about your eligibility or the program we encourage you to contact us at:

Salt Lake City Area: (801) 530-6715
Or
Toll Free Number: (866) 772-8824 (866-PSC-UTAH)

2 **Revised 06/11/2008**

A. Applicant must be participating in one of the following programs administered by the Department of Human Services:

1. Aid to Families with Dependent Children
2. Emergency Work Program
3. Food Stamps
4. General Assistance
5. Home Energy Assistance Target Program and/or Lifeline
6. Medical Assistance (Medicare, Medicaid)
7. Refugee Assistance
8. Supplemental Security Income (SSI) or Social Security Disability Income (SSDI)

OR

B. Applicant must meet the monthly income eligibility limits for Fiscal Year 2005:

II. In addition to either of the income-related requirements above, the individual must have one of the following qualifying conditions:

DEAF: A hearing loss that requires use of a TTY or VCO to communicate effectively on the telephone.

DEAF-BLIND: A hearing loss and a visual impairment that requires use of a TTY with Braille to communicate effectively on the telephone.

HARD OF HEARING: A hearing loss that requires use of a TTY or Amplified Telephone to communicate effectively over the telephone.

SPEECH DISABLED: A speech impairment that renders speech on an ordinary phone unintelligible, thus requiring the use of a TTY or HCO to communicate effectively on the telephone.

LOANED EQUIPMENT AND INSTALLATION

- To best meet your need(s) the PSC program offers in-home testing, installation and training in how to use the phone equipment. At that time we will also answer any questions you may have. The PSC has limited delivery personnel who travel the entire state of Utah and we are currently experiencing a very large demand for loaned equipment. When our delivery personnel are scheduled to be in your area we will contact you prior to that date and schedule a day and time when we can come to your home.
- We request that someone (family, friend, neighbor) be with you at time of testing/installation. Please include their name and contact number on Page 3. If you would like the PSC to contact them and schedule with them your equipment installation appointment please let us know.

APPLICATION FOR AN ASSISTIVE TELECOMMUNICATIONS DEVICE

PART I (To be filled out by Applicant)

- A. I am requesting to borrow: **(CHECK ONE ITEM ONLY)**
 Devices: 1, 4, 5, 6, 8 require completion of page 5 "Certification of Impairment".
 Devices: 2 and 3 require "Certification of Impairment" and a vision certification.
 Device: 7 requires Audiologist complete page 6 "Certification for CapTel Phones"

1	TTY: Ultratec Miniprint 425	
2	TTY with Large Visual Display (PRO80 LVD or 4425 with LVD) (Requires vision certification)	
3	Braille TTY (Requires vision certification)	
4	HCO/VCO phone: HCO Uniphone 1140, Dialogue VCO	
5	Amplified Phone with Caller ID: CSC50, SP45, Ampli 500	
6	Amplified Phone with Pre-Program Feature: CSC50, SP Standard	
7	CapTel (<u>Audiologist must</u> complete form on Page 6, 'Certification for CapTel Phone')	
8	Phone Signaler or Ringer Amplification	
9	Other:	

- B. This device will be loaned to me because I meet **either #1 or #2** of following conditions:

1. If you are receiving assistance from a Department of Human Services administered program, then please mark one or more of the following and proceed to item C. If you are NOT receiving assistance from the Department of Human Services then skip to #2 and then to item C.
 - a. Aid to Families with Dependent Children
 - b. Emergency Work Program
 - c. Food Stamps
 - d. General Assistance
 - e. Home Energy Assistance Target Program and/or Lifeline (emergency phone service)
 - f. Medical Assistance (Medicare, Medicaid)
 - g. Refugee Assistance
 - h. Supplemental Security Income (SSI) or Social Security Disability Income (SSDI)

2. If your income qualifies, but you are not receiving assistance from the Department of Human Services:
 - a. Total Household Income per \$_____/month
 - b. Total Number of Persons Living in Household:_____

- C. Does anyone in your household, including yourself, already own an assistive telecommunications device which functions as it should?
 Yes _____ No _____

- D. Are there any other persons in your household that are already receiving assistance from the Public Service Commission of Utah for an assistive telecommunications device?
 Yes _____ No _____

4 Revised 06/11/2008

E. Please read the following statements. If you are in agreement with them, please sign below. By signing this form, you agree to the following statements and you agree that the information already provided is true and correct to the best of your knowledge.

If I stop receiving assistance and/or monthly income increases, I will IMMEDIATELY notify the Public Service Commission.

I will return the borrowed device to the Public Service Commission if, and when, I no longer reside in the State of Utah.

I understand that if I give false information, I will have to return the device to the Public Service Commission IMMEDIATELY.

I understand that it is my responsibility to obtain telephone service, and I assume the responsibility for payment of all associated fees and charges.

SIGNATURE: _____ DATE: _____

GUARDIAN OR
PARENT SIGNATURE: _____ DATE: _____
(If under 18 years of age)

F. Please provide the following information:

NAME (please print): _____

ADDRESS: _____
Street Address Apt. No.
Post Office Box (If Needed) City Zip code

HOME PHONE NUMBER: (435) (801) _____

DATE OF BIRTH: _____

E-MAIL ADDRESS (Optional): _____
(If you would like to receive updated PSC equipment or Relay Utah information please provide an E-mail address)

PERSON WHO WILL BE WITH ME DURING APPOINTMENT:

Name Phone

Is above individual to be your delivery contact person? _____ YES _____ NO

If 'No' please indicate contact information:

Name Phone

VERIFICATION OF IMPAIRMENT

PART II

I verify that the applicant _____
(applicant's name)
has the following impairment (see item II on page 2)

Deaf ____ Deaf/Blind ____ Severely Hard of Hearing ____

Severely Speech Disabled ____

I am a:

Medical Doctor _____ Audiologist _____

Speech/Language Pathologist ____ Qualified State Employee ____

____ Senior Center Director _____ Health Care Provider

<Do NOT indicate Applicant> ALL information below must be completed by a Professional; i.e. Doctor, Audiologist, Speech/Language Pathologist, Health Care Provider, or a Qualified State Employee with their information)

(Please Print) Last Name First Name Middle Initial

Street Address City Zip Code

Telephone Number

Signature Date

NOTE: Applicant cannot list self or family member as a certified professional.

If there are any questions, then please contact the Public Service Commission at (801) 530-6715 (Voice/TTY), Toll Free at (866) 772-8824 or (801) 530-6796 (Fax).

Equipment Distribution Program Form

Certification for CapTel Phones

Part III: *(To be filled out by an audiologist only.)* In order for the following applicant to be considered for a CapTel phone, the applicant must have his/her audiologist complete this form. A person must qualify by meeting two criteria. The first criteria is that the person have a decibel loss greater than 60. The second criteria is that the person must have a discrimination score less than 70%.

Applicant Name: _____

I certify that the applicant has the following hearing loss:

Percentage DB Loss _____ (greater than 60)

Percentage Discrimination _____ (Less than 70%)

Audiologist Information (Do NOT indicate Applicant information below):

(Please Print) Last Name First Name Middle Initial

Street Address City State Zip Code

Telephone Number

Signature

Date

Note: Applicant must have an audiologist's signature. Turning in an audiogram does not meet the requirement.