

## 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 regarding the status of their request for an assistive device. If approved, the applicant will be notified about how to obtain their device. 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 low-income program designed to provide assistance to those who absolutely cannot afford it on their own. To be considered low-income under this program, the individual must meet one (A and/or B) of the following two conditions:

A. Applicant must be participating in one of the following public assistance 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
7. Refugee Assistance
8. Supplemental Security Income (SSI) or Social Security Disability Income (SSDI)

OR

B. Applicant must meet the following monthly income eligibility limits for Fiscal Year 2001:

<u>HOUSEHOLD SIZE</u>	<u>125% OF POVERTY</u>
1 Person in Household	\$ 950 per month
2 People in Household	\$1,250 per month
3 People in Household	\$1,550 per month
4 People in Household	\$1,850 per month

For each additional person, add \$300 per month.

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.

Equipment Distribution Program Form

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**APPLICATION FOR AN ASSISTIVE TELECOMMUNICATIONS  
DEVICE**

**PART I** (To be filled out by Applicant)

- A. I am requesting to borrow: (CHECK ONE ITEM ONLY)
1. TTY (Ultratec Miniprint 425) \_\_\_\_\_
  2. TTY with Large Visual Display (Ultratec Superprint Pro80 LVD or Superprint 4425 with LVD) \_\_\_\_\_
  3. TTY with Braille \_\_\_\_\_
  4. HCO/VCO phone (Ultratec Uniphone 1140) \_\_\_\_\_
  5. Amplified Phone (Ultratec Crystal Tone) \_\_\_\_\_
  6. CapTel Phone (Will need to fill out additional form) \_\_\_\_\_
- B. This device will be loaned to me because I am low income and/or I am receiving assistance from the Department of Human Services
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
    - 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 (refer to item B on page 2):
    - a. Total Household Income is \$ \_\_\_\_\_/month
    - b. Total Number of Persons Living in Household is: \_\_\_\_\_



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**CERTIFICATION OF IMPAIRMENT**

**PART II** (To be filled out by a certified professional, refer to item A on page 1)

A. I certify 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 \_\_\_\_\_

\_\_\_\_\_  
(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) 530-6638 or (801) 530-6796 (fax).*

*Send application to: Public Service Commission  
Equipment Distribution Program  
160 E. 300 S., 4<sup>th</sup> Floor  
Salt Lake City,  
UT 84111*

# Equipment Distribution Program Form

## Certification for CapTel Phones

**Part III:** (To be filled out by an audiologist.) 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:

DB Loss \_\_\_\_\_ (greater than 60)

Discrimination \_\_\_\_\_ (Less than 70%)

### **Audiologist Information:**

\_\_\_\_\_  
(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.**