

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	\$1,575 per month
4 People in Household	\$1,900 per month
5 People in Household	\$2225 per month
6 People in Household	\$2550 per month
7 People in Household	\$2850 per month
8 People in Household	\$3175 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.

**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) _____
- 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: _____
- C. Does anyone in your household, including yourself, already own an assistive telecommunications device that functions as it should?

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 _____

E. Please read the following statements. If you are in agreement with then, 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 City Zip code

HOME PHONE NUMBER: (435) (801) _____

SOCIAL SECURITY NUMBER: _____ - _____ - _____

(Do not forget to have a Certified Professional fill out the next page)

Equipment Distribution Program Form

Page 5

CERTIFICATION OF DISABILITY

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

A. I certify that the applicant has the following disability (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.