TELECOMMUNICATIONS ACCESS PROGRAM
A Program of the Department of Career Education
Arkansas Rehabilitation Services Division
P.O. Box 3781, Little Rock, AR 72203

1 (800) 981-4463 Toll-Free
(501) 683-3011 Fax

APPLICATION

APPLICANT INFORMATION

Are you a resident of Arkansas? ..... Yes ☐ No ☐

Are you a client of Arkansas Rehabilitation Services? ..... Yes ☐ No ☐

Have you applied for TAP equipment in the past? ..... Yes ☐ No ☐

If marked "Yes," when?_____(Reapplication required every 3 years if asking for other equipment, or sooner if TAP requests updated information)

Do you have residential land line phone service? ..... Yes ☐ No ☐

Do you have cell phone service? ..... Yes ☐ No ☐

You may be asked for further documentation before receiving equipment.

How do you communicate? Check all that apply.

Sign Language ☐ Speech ☐ Writing ☐

Name of Applicant (Last, First, Middle Initial):

Social Security Number (last four only)	Date of Birth (mm/dd/yyyy)	Race/Ethnicity	Sex
____ ____ ____ ____			Male ☐ Female ☐

Street Address

City	State	Zip Code	County

Mailing Address (if different from above)	City	State	Zip Code

Home Telephone Number	Alternate Telephone Number(s)	
( )	( )	( )

Email Address

OTHER CONTACT PERSON

(Provide the contact information for a person you allow to speak on your behalf)

Name

Address

City	State	Zip Code	County

Home Telephone Number	Alternate Telephone Number	Relationship to you
( )	( )	

revised 2017

TELEPHONE SERVICE

Please note: There may be compatibility issues with some types of phones and phone service providers resulting in a phone not functioning properly.

What is the name of your telephone service provider?_____

What does your phone cord plug into? (please check one)

- ☐ Plugs into a modem
- ☐ Plugs into a standard phone jack
- ☐ Plugs into a wireless box
- ☐ Not sure
- ☐ Other_____

Do you have internet service?..... Yes ☐ No ☐

If marked "Yes," what type of service?

☐ Cable ☐ VoIP ☐ DSL ☐ Not Sure

Do you have Caller ID service? ..... Yes ☐ No ☐

If marked "Yes," do you want a phone with Caller ID capabilities?..... Yes ☐ No ☐

FINANCIAL INFORMATION

Annual gross income of the applicant:..... $ _____

What is the source of your income? _____

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

REFERRAL

How did you learn about TAP?

- ☐ Newspaper/TV
- ☐ Audiologist/Doctor
- ☐ Friend/Family
- ☐ Health Fair
- ☐ ARS staff
- ☐ Website
- ☐ Presentation
- ☐ Other: _____

By signing this application, I understand and accept the **Conditions of Acceptance** (pages 7-8) and certify that the information I have given is true.

_____ _____

*Applicant's Signature** *Date*

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

AVAILABLE EQUIPMENT

Please choose the appropriate category for the equipment you are requesting.
TAP staff may assist you in finding equipment that meets your needs.

Will you need training: Yes ☐ No ☐ Not Sure ☐

DEAF/PROFOUND HEARING LOSS

Several models of captioned phones are available for users with profound hearing loss.
Requirements: Telephone service, standard electrical power outlet.
Certification form must be signed by a licensed hearing healthcare professional.

☐ Captioned phone: Captions are displayed to user. (TAP staff will assist with selection of appropriate model.)

☐ TTY: User types message instead of speaking

HARD OF HEARING

Amplified phones allow the user to increase volume and/or adjust tone of the incoming voice. Most models have visual signals and loud ringers.

☐ Cordless amplified phone

☐ Corded amplified phone

☐ In-line amplifier for use with existing corded phone See "Cell Phones/Smartphones" section for cellular options.

LOW VISION OR BLIND

☐ Phone with talking keypad and talking Caller

☐ ID Phone with Braille characters

See "Cell Phones/Smartphones" section for details on Jitterbug phone for low vision.

SPEECH OR VOICE IMPAIRMENT

☐ Portable voice amplifier

☐ Outgoing speech amplified phone

☐ Hearing carry-over phone (allows speech-impaired individual to communicate by using a combination text telephone and standard phone through the relay service)

☐ Electrolarynx (specific model must be recommended by person who signs the Eligibility Certification)

MOBILITY IMPAIRMENT

☐ Hands-free remote-controlled speakerphone

☐ Bluetooth switch to access devices with built-in Bluetooth

COGNITIVE IMPAIRMENT

For users with 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.

- ☐ Photo phone with auto-dial memory buttons

CELL PHONES/SMARTPHONES

A variety of cell phones, including Jitterbug models, are available for different disability needs. Service provider will vary depending on phone. Application process requires approval through TAP.

- ☐ Smartphone through Sprint, 2-year contract required
- ☐ Smartphone through GreatCall (network provider Verizon), no contract required
- ☐ Non-smartphone through GreatCall (network provider Verizon), no contract required

TAP provides the devices only, not the service.

CELL PHONE AMPLIFICATION ACCESSORIES

- ☐ Wired loopset. For users with telecoil equipped hearing aids. Uses cable to connect to cell phone.
- ☐ Handheld cell phone amplifier for cell phones with Bluetooth settings; features adjustable tone and speaker mode for hands free calls; does not require hearing aid.
- ☐ Wireless Bluetooth amplified cellular loopset; can be connected to any Bluetooth device and can be used with telelcoil or non-telecoil hearing aids.

SIGNALING DEVICES

If you have trouble hearing the phone ring, please check **one** of the choices below:

- ☐ Audible -- loud ringer, for hard of hearing
- ☐ Visual -- connects to lamp; light flashes on and off when phone rings. For deaf or severe to profound hearing loss
- ☐ Combination -- visual and audible; includes loud ringer and flashing light
- ☐ Wireless -- cell phone ringer/flasher; this is a stationary device for home use

OTHER

- ☐ Emergency phone -- Amplified speakerphone with wristwatch-style remote control transmitter. User presses remote control and the phone will automatically dial pre-programmed contacts until there is an answer.
- ☐ Deaf-Blind -- Users should contact icanconnect.org, or
  World Services for the Blind: 501-664-7100 or 1-800-825-4595

ELIGIBILITY CERTIFICATION (TO BE COMPLETED BY THE CERTIFIER)

_____ _____

Name of Applicant (Last, First, Middle Initial) *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/profound hearing loss: A hearing loss of such severity that requires use of a captioned phone, TTY, or other specialized equipment.

☐ Deaf-Blind: A significant combined vision and hearing disability.

☐ Hard of Hearing: A hearing loss that requires use of an amplified telephone or other specialized equipment.
Type of hearing aid(s) if applicable: T-coil? Yes ☐ No ☐ Not Sure ☐

☐ Mobility Impairment: A physical upper 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:

TruTone™ Electrolarynx ☐ Servox® digital speech aid ☐ Servox® Inton Speech Aid ☐

Description of disability and limitations: _____

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

☐ Physician	☐ ARS qualified staff	☐ AR School for the Deaf qualified staff
☐ Audiologist	☐ Social Worker	☐ Division of Services for the Blind Counselor
☐ Speech Pathologist	☐ Case Manager	☐ AR Spinal Cord Commission Counselor
☐ Occupational Therapist	☐ Ophthalmologist	☐ Home Health Professional
☐ Physical Therapist	☐ Optometrist	☐ Hearing Aid Dealer/Specialist
☐ Neuropsychologist	☐ Nurse	

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.

_____ _____

Certifier's Signature *Date*

_____ _____

Printed Name *Title*

_____ _____ AR _____

Mailing Address *City* *State* *Zip Code*

_____ _____ _____

Telephone No. *Fax No.* *License No. (if applicable)*

_____

Email Address

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 (a police or fire report must be sent to TAP), or damaged by something out of my control.
   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 800-981-4463 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 800-981-4463 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.

CONDITIONS OF ACCEPTANCE (cont.):

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 is 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 denial of future services.

YOUR RIGHTS:

Fair Treatment
Arkansas Rehabilitation Services is in compliance with Titles VI and VII of the Civil Rights Act and the Americans with Disabilities Act. It does not discriminate with 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 Ave., Little Rock, AR 72201 or call 800-330-0632.

Need to contact us?

Phone: **501-686-9693**
Toll Free: **800-981-4463**
Fax: **501-683-3011**

Our office hours are 8:00 a.m. - 4:30 p.m., Monday - Friday
(Customers will be seen by appointment only)