Kentucky Commission on the Deaf and Hard of Hearing | 632 Versailles Rd | Frankfort, KY 40601
(800) 372-2907 (V/T)| (502) 416-0607 Videophone | (502) 573-3594 Fax | kcdhh@kcdhh.ky.gov

KCDHH
Kentucky Commission on the Deaf and Hard of Hearing

Telecommunications Access Program
APPLICATION & CERTIFICATION

APPLICANT INFORMATION

Applicant's First Name:_____ **MI:**____ **Last:**_____ **Maiden:**_____

Date of birth:_____ **Last four digits of Social Security Number:** _____ **(OPTIONAL)**

Street address (Must be 911) or Residential: _____

City:_____ **State:**_____ **Zip Code:**_____

Mailing address (PO Box permitted): _____

Shipping Address (If different from street): _____

City:_____ **State:**_____ **Zip Code:**_____

Telephone: (_____) _____ **or VP# (_____)** _____

Email Address:_____

Hearing Status:

- ☐ Deaf
- ☐ Hard of Hearing
- ☐ Late-Deafened
- ☐ Severely Hard of Hearing
- ☐ Speech Impaired
- ☐ Deaf and Blind
- ☐ Deaf with Limited Vision
- ☐ Hard of Hearing with Limited Vision

KY resident more than one year? ☐**Yes** ☐**No**

Do you have power of attorney? ☐**Yes** ☐**No**
If yes, must provide copy of POA document.

Active Vocational Rehabilitation client? ☐**Yes** ☐**No**
If yes, must provide letter from VR.

STATEMENT OF UNDERSTANDING

I_____, attest and understand the following:
(PLEASE PRINT YOUR NAME)

All information on this application is true and I agree to notify the KCDHH Telecommunications Access Program (TAP) of any changes in my information. I can apply online using an electronic application and submit my verification electronically, if I choose, through KCDHH website: *https://www.kcdhh.ky.gov* I am unable to use regular telephone services without specialized telecommunications equipment (STE). If any information provided is false, I must return the equipment to the TAP and will be disqualified. If I sell, trade or gift the STE to another individual, I will be disqualified. I accept full responsibility for the equipment, accessories, supplies and all service bills associated with its use. The TAP has a limited amount of funds. There is a possibility that applicants may be placed on a waiting list due to a large number of applications. The STE shall be distributed on a nondiscriminatory, first-come, first-serve basis. Only one telecommunications device and one signaler per individual or household is distributed, depending on the STE selected.

Applicant's Signature: _____ **Date**_____
Print Parent/Guardian Name: _____
Parent/Guardian Signature _____ **Date**_____
(PARENT/GUARDIAN SIGNATURE REQUIRED IF APPLICANT IS AGE 5-17)

FOR OFFICE USE ONLY: Approved:_____ **Date:**_____ **App #:**_____

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PROFESSIONAL CERTIFICATION

APPLICANTS DO NOT COMPLETE THIS SECTION.

The certification is to be completed by a licensed professional who serves deaf, hard of hearing and/or speech-impaired individuals. Applicants who are deaf-blind or deaf with limited vision must include additional certification on official letterhead from a licensed eye specialist to qualify for some equipment. Speech-impaired applicants must provide certification from a licensed speech-language pathologist.

Licensed Professional or Agency (*prior approval required for agency head*):

- ☐ Audiologist
- ☐ Speech-Language Pathologist
- ☐ Hearing Instrument Specialist
- ☐ Advanced Practice Registered Nurse
- ☐ Physician (Family, ENT or Internal Medicine)
- ☐ Eye Specialist (for vision loss only)
- ☐ Physician's Assistant-Certified
- ☐ Director Public/Private Agency: (Requires preapproval)

Name:_____ **Title:**_____

(PLEASE PRINT/TYPE)

Address:_____

City_____ **State**_____ **Zip Code**_____

Telephone: _____ **State License #** _____

"I certify that the applicant has a hearing loss, speech impairment or vision loss as verified which restricts the person's use of telecommunication services."

Professional's Signature _____

The person applying to receive specialized telecommunications equipment, which will enable them to access telecommunications, must verify their disability. Please verify whether the applicant's hearing loss, speech impairment or vision loss will prevent or cause a reduced ability to use telecommunication services. Attach any supporting documentation. *If you have any questions, please call the Kentucky Commission on the Deaf and Hard of Hearing at (800) 372-2907 (V/T).*

MAIL OR DELIVER TO:

IF YOU DO NOT POSSESS A KENTUCKY MEDICAL LICENSE, VERIFICATION MUST BE SUBMITTED ON PROFESSIONAL LETTERHEAD AND YOUR STATE LICENSE NUMBER MUST BE LISTED ON THE LETTERHEAD.

APPLICANT STATUS

Have you applied for the Telecommunications Access Program (TAP) before? ☐ Yes ☐ No

Are you applying to replace the equipment you already received from this program? ☐ Yes ☐ No

If yes, why do you need to replace the equipment? **Please check one below:**

- ☐ It has been four (4) years or the equipment is non-functional.
  (You must verify that the equipment is no longer functional.)
- ☐ A new and more appropriate device is available through this program.
  (As determined by KCDHH staff.)
- ☐ Disability status has changed. (Professional verification letter is required.)
- ☐ STE was stolen or destroyed by natural disaster.
  (Verification required as determined by KCDHH staff.)

First time applicants are served before reapplicants when considering first-come, first-serve priority.

EQUIPMENT SELECTION

EQUIPMENT CANNOT BE EXCHANGED AFTER YOU RECEIVE IT, SO CHOOSE CAREFULLY!

LANDLINE APPLICANTS: You **MUST** attach a copy of your telephone bill. If the applicant's name is not on the telephone bill or the address is different from your application, you **MUST** attach a copy of your Kentucky Driver's License or other verification as approved by program staff.

WIRELESS APPLICANTS: You **MUST** submit a copy of a valid Kentucky Driver's License or other official ID showing legal Kentucky residency.

Complete this section by writing the name of the equipment you and your hearing, speech or vision loss professional recommended. Choose equipment from the brochure provided. Be VERY careful to write the correct name of equipment you wish to obtain, as you cannot exchange after receipt.

Telephone or Wireless Equipment

Device Name _____

Signaler Equipment

Device Name _____

Do you need training to use the above selected devices? ☐ Yes ☐ No

For more detailed information on devices, PLEASE SEE OUR DEVICE LISTS ONLINE AT
https://www.kcdhh.ky.gov/oea/whatequip.html

TELECOMMUNICATIONS ACCESS PROGRAM

The 1994 Kentucky General Assembly enacted legislation which directed the Kentucky Commission on the Deaf and Hard of Hearing (KCDHH) to establish a program to distribute specialized telecommunications equipment (STE), to deaf, hard of hearing and speech impaired persons in Kentucky. The distribution program is funded through a surcharge on Kentucky telecommunication access lines. Household income is not considered when determining eligibility. This program increases the accessibility of the telecommunications system to persons who are deaf, hard of hearing, deaf blind or speech-impaired.

Applicants must meet the following criteria:

- Be a legal resident of the state of Kentucky for at least one year. Official identification shall be provided by the applicant, with a matching address as listed on the application, to establish residency.
- The minimum age of an applicant shall be five (5) years. For a wireless device the applicant shall be thirteen (13) years of age. In the case of applicants between five (5) and eighteen (18) years of age, parents or guardians shall apply on behalf of applicants and assume full responsibility for the equipment;
- Be deaf, hard of hearing, deaf blind or speech-impaired such that the applicant cannot use telecommunications equipment for communication without adaptive equipment. Applicants shall provide, at their own expense, professional verification that they are deaf, hard of hearing, deaf blind or speech impaired. A licensed physician; GP, IM, ENT or an APRN or PAC, or an audiologist, hearing instrument specialist, speech pathologist or eye specialist must provide this verification. Verification of vision loss shall be requested to qualify for some equipment.

Upon request, applicants shall provide a copy of the telephone bill that shows the *name*, *address*, and *telephone number* on the bill. If the name on the telephone bill does not match the name on the application, ID must be provided by the applicant with a matching address. Identification must be provided for wireless devices.

BEFORE SENDING IN THIS APPLICATION, PLEASE CHECK THE FOLLOWING:

- **Did you fill out the application completely? Either hardcopy or online?**
- **Do you have all necessary signatures, including yours? *(Electronic accepted if applicable.)***
- **Did you pick (write in) the equipment you want to receive?**
- **Did you enclose a copy of your most recent telephone bill, if requested? (Send us a copy of the page that shows the ***name***, ***address***, and ***telephone*** number.)**
- **Did you provide an official ID that shows the address as listed on the application?**
- **If ordering a wireless device, enclose the signed TAP Wireless Agreement.**
- **You may submit an application and provide verification electronically if you choose.**

If you have questions, please contact the KCDHH office for more information before submitting.

*All applicants shall be afforded equal access without regard to age, sex, race, color, religion, National origin, political affiliation or disability. All information is held **strictly confidential**.*

MAIL OR DELIVER TO:

KCDHH
Telecommunications Access Program
632 Versailles Road, Frankfort, KY 40601

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