

# TELECOMMUNICATIONS ACCESS PROGRAM

A Program of the Department of Career Education  
Arkansas Rehabilitation Services Division  
PO Box 3781, Little Rock, AR 72203

1-(800)-981-4463 (V/TTY)  
FAX (501) 683-3011  
www.ace.arkansas.gov

## APPLICATION

(Will be seen by appointment only)

### APPLICANT INFORMATION

I am a resident of Arkansas Yes  No

Are you an Arkansas Rehabilitation Services' client? 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.) \_\_\_\_\_

I have phone service or personal telecommunication service and/or will have service within 30 days (You may be asked for further documentation before receiving equipment). **Caution: Equipment may or may not work with digital, cable or satellite and/or may damage equipment.** Yes  No

What is your mode of communication? Sign Language  Speech  Written

Name of Applicant (Last, First, Middle Initial)

Social Security Number (last four)	Date of Birth (mm/dd/yyyy)	Race/Ethnicity	Sex Male <input type="checkbox"/> Female <input type="checkbox"/>
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Physical Street Address

City	State	Zip Code	County
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Mailing Address (if different from above)	City	State	Zip Code
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Home Telephone No. ( )	Type of phone (check one) Voice <input type="checkbox"/> TTY <input type="checkbox"/> VP <input type="checkbox"/>	Alternate Telephone No. ( )	Type of phone (check one) Voice <input type="checkbox"/> TTY <input type="checkbox"/> VP <input type="checkbox"/>
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Email Address

## OTHER CONTACT PERSON

( Please provide contact information for a person not living with you)

Name \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_

State \_\_\_\_\_

Zip Code \_\_\_\_\_

Home Telephone No. \_\_\_\_\_

Type (check one)

Relationship to you \_\_\_\_\_

(      )

V  TTY  VP

## 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?  
\_\_\_\_\_

Do you have high speed internet or DSL?

Yes  No

Do you have caller ID service?

Yes  No

If marked yes, do you want a phone with Caller ID capabilities?

Yes  No

## FINANCIAL INFORMATION

Total number of family members living in household \_\_\_\_\_

Annual gross income of the applicant

\$ \_\_\_\_\_

What is the source of your income? \_\_\_\_\_

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

## REFERRAL

How did you learn about TAP?

Newspaper/TV

Health Fair

Audiologist/Doctor

Website

Friend/Family

ARS Staff

Presentation

Other (please explain)  \_\_\_\_\_

**EQUIPMENT AVAILABLE:**

The following are examples of equipment available. Please check the equipment you are requesting. TAP staff may assist you in finding equipment that meets your needs.

**Do you or will you need training?**

Yes  No

**PLEASE CHECK ONLY ONE**

- Amplified Phone:** Allows a hard of hearing user to increase the volume and adjust the tone of the incoming voice.
- Amplified Phone with Speakerphone**
- Amplified Emergency Phone:** This is an amplified speakerphone featuring a wrist-watch style remote control transmitter. In the event of an emergency, the transmitter can be pressed and the phone will automatically dial pre-programmed contacts until there is an answer.
- Cordless Amplified Phone**
- In-line Telephone Amplifier:** Provides moderate amplification and is compatible for most corded phones.
- Captioned Telephone (CapTel 840):** Captioned telephone that allows a severely hard of hearing user to speak for them and read incoming text through a captioning service. This model will only work with landline phones (phones that are directly plugged into a wall jack) or some phones with DSL internet service.
- Captioned Telephone (CapTel 840i):** This is much like the model described above except that this model is especially designed to connect with both telephone service *and* internet service. When a user makes a phone call, the phone uses the internet connection to access the free captioning service.
- Hands Free Telephone:** Allows a mobility impaired individual independent communication through the use of a remote control speaker phone with optional headset and/or other special features.
- Phones Compatible with Augmentative Communication Devices:** Allows speech and/or mobility impaired users a means to use their device with a compatible phone.
- Amplified Telephone with Talking Keypad:** Allows a blind or low vision user to hear the numbers on the keypad as they are pressed.

- Amplified Telephone with Talking Keypad and Talking Caller ID:** Allows a blind or low vision user to hear the numbers on the keypad and the phone number of the caller.
- Cordless Amplified Telephone with Talking Keypad and Talking Caller ID**
- Hearing Carry-Over Phone:** Allows speech impaired individuals to communicate by using a combination text telephone and standard phone through the relay service.
- Electrolarynx:** Handheld, portable voice aid which allows people who have lost use of their larynx a means to communicate. (Specific electrolarynx must be recommended by the person who signs the Eligibility Certification)
- Portable Voice Amplifier:** Allows a speech impaired user with low speech to amplify their outgoing voice. This portable voice amplifier could be a great companion to an electrolarynx.
- Outgoing Speech Amplified Phone:** Allows a speech impaired user with low speech to amplify their outgoing voice.
- TTY:** Allows a deaf user to send and receive typed messages.
- TTY with Braille:** Allows deaf-blind individuals to send and receive Braille messages.
- TTY or Q90 with Large Visual Display:** Allows deaf users with severe low vision to send and receive typed messages on a large screen.
- DeafBlind Communicator:** Allows deaf-blind individuals that can read Braille a means to communicate.
- Photo Phone:** Telephone with photo auto-dial memory buttons that allows easier dialing for someone with cognitive impairments.
- Wired Amplifying Cellular Loopset:** Allows T-coil equipped hearing aid users to receive amplification on a cordless phone or cell phone through the use of a cable.
- Wireless Bluetooth Amplifying Cellular Loopset/Headset:** Allows either T-coil equipped hearing aid users or non-T-coil/non-hearing aid users to receive amplification on a cell phone. Must have a Bluetooth option on your cell phone. This can also be paired with an amplified cordless phone with Bluetooth.
- Amplified Phone for cellular service:** Allows a cell phone with Bluetooth to be connected and used for phone service.
- Jitterbug cell phone:** The Jitterbug J has big buttons and a large bright screen, so it's easier to see for those with low vision. It also has a padded earpiece that helps keep

unwanted noises out to help you hear conversations more clearly. There is a short separate application to fill out if you are requesting the jitterbug. Please contact our office and we will send it to you or you can go online at [www.ace.arkansas.gov](http://www.ace.arkansas.gov) and download it. (Network provider for the Jitterbug is through Verizon.

- Wireless (cellular) Phone:** We offer a variety of cell phones meeting all disability needs. You may view available cell phones through TAP at [www.pcsorders.com/tapar](http://www.pcsorders.com/tapar) or you can contact our office for more information. **You may not order any equipment from this website until you have filled out this application and been approved by TAP. The service provider is Sprint.**

## SIGNALING DEVICES

If you need a device to alert you when the phone rings please check **one** of the choices below:

- Audible Ringer:** Loud ringer that alerts a hard of hearing person that the phone is ringing.
- Visual Signaler:** A flashing light that connects to a lamp which flashes on and off when the phone rings to alert a deaf or severely hard of hearing individual that the phone is ringing.
- Combination Signaler:** A combination strobe light and loud ringer that alerts a hard of hearing person that the phone is ringing.
- Tactile Ringer:** A vibrating ringer that alerts a deaf-blind individual that the phone is ringing
- DreamZon wireless signaler** – a call detector with light signal for wireless phones.

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.**

**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: A hearing loss of such severity that requires use of a TTY or other specialized equipment.
- Deaf-Blind: A hearing loss accompanied with vision loss that prohibits use of a standard telephone and TTY.
- Hard of Hearing: A hearing loss that requires use of an amplified telephone or other specialized equipment.
- Mobility Impairment: A physical upper and/or lower 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: \_\_\_\_\_

Description of disability and limitations: \_\_\_\_\_

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

- |   |  |   |
|---|--|---|
| <input type="checkbox"/> Physician              | <input type="checkbox"/> ARS qualified staff | <input type="checkbox"/> Arkansas School for the Deaf qualified staff |
| <input type="checkbox"/> Audiologist            | <input type="checkbox"/> Social Worker       | <input type="checkbox"/> Division of Services for the Blind Counselor |
| <input type="checkbox"/> Speech Pathologist     | <input type="checkbox"/> Case Manager        | <input type="checkbox"/> Arkansas Spinal Cord Commission Counselor    |
| <input type="checkbox"/> Occupational Therapist | <input type="checkbox"/> Ophthalmologist     | <input type="checkbox"/> Home Health Professional                     |
| <input type="checkbox"/> Physical Therapist     | <input type="checkbox"/> Optometrist         | <input type="checkbox"/> Hearing Aid Dealer/Specialist                |
| <input type="checkbox"/> Neuropsychologist      | <input type="checkbox"/> 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

Mailing Address

City

AR

State

Zip Code

( )

( )

Telephone No.

Fax No.

License # (if applicable)

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**KEEP THIS PAGE FOR YOUR RECORDS**

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**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, or damaged by something out of my control. (A police or fire report must be sent to TAP)
  - 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.
4. (Individual must still be approved by TAP and re-application may be necessary after the two year time period).
5. 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.
6. I understand I need to contact TAP at 1-800-981-4463 (V/TTY) 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).

7. If my equipment stops working, I will not try to fix it but will contact TAP at 1-800-981-4463 (V/TTY) for instructions as to what I need to do.
8. 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.
9. I am responsible for all extra materials including batteries, light bulbs, electrolarynx accessories and other miscellaneous supplies.
10. 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).
11. I understand that this agreement is binding for any additional or exchanged equipment that I receive from the program.
12. I understand it 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 me being denied participation in the equipment program.

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**YOUR RIGHTS:****Fair Treatment**

Arkansas Rehabilitation Services is in compliance with Titles VI and VII of the Civil Rights Act, the Americans with Disabilities Act and is operated, managed and delivers services without 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, Little Rock, AR 72201 or call 1-800-330-0632 (V/TTY).

**Need to contact us?**

Voice/TTY 1-800-981-4463

Voice/TTY 501-686-9693

VP 501-246-8219

Fax 501-683-3011

Office Hours: Monday - Friday: 8:00 - 4:30 **(Will be seen by appointment only)**