

AIDB-Tuscaloosa Regional Center
ATAP Program
2412 Skyland Blvd. East
Tuscaloosa, AL 35405



Who is eligible to receive equipment?

Under ATAP, only low-income individuals who are deaf, hard of hearing, speech disabled or deaf-blind are eligible to receive equipment provided

through ATAP. Applicants must:

- Be an Alabama resident (proof of residency can be shown by most current utility bills);
- Persons under the age of 18 must have application signed by parent/guardian);
- Be certified as deaf, hard of hearing, speech disabled or deaf-blind;
- Have existing home telephone (land line); and
- Meet income eligibility requirements for household* size (*see chart below*)

Income eligibility

Number of persons in family/household Annual Gross Income

1	\$ 34,590
2	\$ 46,760
3	\$ 58,930
4	\$ 71,100
5	\$83,270
6	\$95,440
7	\$107,610
8	\$119,780
For each additional person, add	\$ 12,170

For purposes of determining income eligibility for the ATAP, AIDB defines “income” and “household” as follows:

“Income” is all income actually received by all members of a household. This includes salary before deductions for taxes, public assistance benefits, social security payments, pensions, unemployment compensation, veteran's benefits, inheritances, alimony, child support payments, worker's compensation benefits, gifts, lottery winnings, and the like. The only exceptions are student financial aid, military housing and cost-of-living allowances, irregular income from occasional small jobs such as baby-sitting or lawn mowing, and the like.

A “household” is any individual or group of individuals who are living together at the same address as one economic unit. A household may include related and unrelated persons. An “economic unit” consists of all adult individuals contributing to and sharing in the income and expenses of a household. An adult is any person eighteen years or older. If an adult has no or minimal income, and lives with someone who provides financial support to him/her, both people shall be considered part of the same household. Children under the age of eighteen living with their parents or guardians are considered to be part of the same household as their parents or guardians.

See Section 2 for the family/household income information that must be provided with this application.

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Who can attest to a person's disability eligibility?

A practicing professional who has direct knowledge of the person's vision and hearing loss, such as:

- Audiologist
- Community-based service provider
- Educator
- Hearing professional
- Helen Keller National Ctr Representative
- Medical/health professional
- School for the deaf and/or blind
- Specialist in Deaf-Blindness
- Speech pathologist
- State equipment/assistive technology program
- Vision professional
- Vocational Rehabilitation counsellor

Such professionals may also include, in the attestation, information about the individual's functional abilities to use telecommunications, Internet access, and advanced communications services in various settings.

Existing documentation that a person is deaf-blind, such as an individualized education program (IEP), or a statement from a public or private agency, such as a Social Security determination letter, may serve as verification of disability.

See Section 3 for the disability attestation information that must be provided with this application.

Confidentiality Policy

ATAP is committed to ensuring that your privacy is protected. Information provided on this application form will only be used to determine eligibility for ATAP products and services. ATAP will not sell, distribute or lease your personal information to third parties unless you give permission, or if the ATAP program is required by law to do so. ATAP is committed to ensuring that personal information is secure. In order to prevent unauthorized access or disclosure, suitable physical, electronic and managerial procedures are in place to safeguard and secure the information ATAP collects.

Application Section 2 of 3:

Applicant's Personal Data

(Please fill in all fields)

Name:



Address: _____

City: _____ State: _____ Zip: _____ County: _____

Are you a current VR Client? Yes No

Phone: _____ Voice TTY VP

Cell Phone: _____ Email: _____

Cell Phone: _____ Email: _____

Communication Preference: ___ TTY ___ VP ___ CapTel ___ Cell Phone ___ TRS
___ VRS ___ Email ___ Fax

Date of birth: _____ Gender: _____ Race: _____

Language preference: _____

Feedback/suggestions (optional): _____

Alternate Contact (in case of emergency): _____

Address: _____

Phone: _____ Cell Phone: _____ Email: _____

Alternate Contact's Communication Preference: ___ TTY ___ VP ___ CapTel
___ Cell Phone ___ TRS ___ VRS ___ Email ___ Fax

How did you hear about this program?

- AIDB website
- AIDB Representative
- Health Fair / Senior Center
- Disability advocacy group
- Education provider/school
- Family member / Friend
- Current ATAP Recipient
- Healthcare provider
- Helen Keller National Center (HKNC) representative
- Independent Living Center
- Interpreter
- Media/news
- Specialist in Deaf-Blind Services
- State Deaf-Blind Project
- Technology vendor
- Vocational Rehabilitation Counselor
- Other – _____



Income eligibility

To confirm your income eligibility, please provide your eligibility for one of the following federal programs:

- Medicaid
- Low income home energy assistance
- Supplemental Security Income (SSI)
- Federal public housing assistance or Section 8
- Food Stamps or Supplement Nutrition Assistance Program (SNAP)
- Temporary Assistance for Needy Families (TANF) or Welfare to Work (WTW)
- National School Lunch Program's free lunch program

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If none of the above apply, please provide a copy of last year's Federal IRS 1040 tax form(s) filed by you and members of your family/household, or send other evidence of your family/household income, such as recent Social Security Administration retirement benefit statement(s) or other pension benefit statement(s).

With my signature below I hereby request services and certify that:

- 1) the information I have provided in this application is true and accurate to the best of my knowledge;
- 2) the document(s) submitted represent the entire income for my family/household; and
- 3) I authorize the confidential release of the disability and income information I have provided for use solely as required for the administration of my application.

I acknowledge that I am subject to audit and if it is found that I have provided inaccurate information on this form, I will be prosecuted to the fullest extent allowable by law. Should I become eligible for services, I agree to use these services solely for the purposes intended. I further understand that I may not sell, mortgage, lend or transfer interest in any equipment or services provided to me. Falsification of any records or failure to comply with these provisions will result in the immediate termination of service.

Print name of applicant or parent/guardian (if applicant is under age 18):

Signature: _____ **Date:** _____

Application Section 3 of 3:

Disability Verification



This disability verification section is to be completed by the AIDB Director/Designee acting within the scope of his/her job, by an authorized representative of a State agency, by an educational institution or practicing professional who has direct knowledge of the person's hearing/vision loss:

Please complete the following fields, and sign and date at the bottom.

Name and Address of ATAP Applicant:

Name: _____

Street address: _____ **City/state/zip:** _____

Attester:

Name: _____ **Title:** _____

Agency: _____

E-mail: _____ **Phone:** _____

Street address: _____ **City/state/zip:** _____

I certify under penalty of perjury that, to the best of my knowledge, this individual has one of the following disabilities which severely restricts his/her receptive or expressive use of the telephone and qualities of equipment:
(Check all that apply)

qualities of equipment:
(Check all that apply)

Deaf/Deafened – person with a severe or profound hearing loss, who relies on a text-based system, such as a TDD, to effectively use the telephone – cannot benefit from telephone amplification.

Hard of Hearing – person with a hearing loss who is unable to effectively hear speech via the telephone without amplification or visual text display.

Speech Impaired – a person with a speech disability who is unable to speak intelligibly or loudly on the telephone.

Deaf/Blind – a person with a severe to profound hearing loss and a loss of sight, where vision with correction is 20/200 or less in the better eye, or if the visual field is reduced to a radius of 10 degrees or less, and who relies on a text/Braille-based system to effectively use the telephone.

Signature: _____ **Date:** _____

You may be asked to have an assessment to determine the correct equipment for you.

The Alabama Telecommunications Access Program will make FINAL determination.

Please note: *Once your application has been approved, ATAP will notify you and arrange for the designated AIDB Regional Center to receive your equipment. If training is necessary, arrangements should be made at the time your equipment is picked up at the Regional Center.*

Authorized Signature & Title of Regional Center Representative

Date

Regional Center

Phone Number

Email Address

I authorize ATAP/AIDB to have access to and use of the information contained in this Disability Verification form. I also authorize ATAP/AIDB to keep a record of application and equipment loan information for auditing and reporting purposes.

PRINT NAME: _____ DATE: _____

DATE: _____

SIGNATURE OF APPLICANT or PARENT/GUARDIAN

STATEMENT OF TERMS AND CONDITIONS FOR ACCEPTANCE OF STATE PROPERTY FOR PERSONAL USE

STATE PROPERTY - The telecommunications equipment is the property of the State of Alabama. The equipment is loaned to me for my personal use with a telephone and I may use it for as long as I am a resident of this State. The conditions of my use are: 1 – I will not sell, pawn, give away, loan or otherwise transfer any rights I might have to this equipment to others and 2 – I will comply with all of the terms and conditions of this statement which I voluntarily agree to sign.

USE & CARE - The equipment is for use as a telephone and I will not use or allow it to be used for any other purposes. I

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USE & CARE - The equipment is for use as a telephone and I will not use or allow it to be used for any other purposes. I agree to protect equipment from damage by rain, heat and physical abuse. Payment must be made at time of request for repair. The Manufacturer reserves the right to determine if the equipment is covered by the warranty. Equipment may be replaced free of charge for normal wear and tear up to 3 years from issue date. A person who returns equipment more than 3 years after issue date must reapply for replacement equipment.

DAMAGE - If equipment is non-functional, I will NOT try to repair or disassemble equipment. I understand that if I try to repair or disassemble equipment, it will void the manufacturer's warranty and I will be required to pay for repairs on the equipment. When repair is necessary, I will send or return the equipment to the regional center where it was originally received along with payment for repairs.

THEFT - If my equipment is stolen, I will report it immediately to police. Additionally, I will mail a copy of the police report to AIDB-Tuscaloosa Regional Center, 2412 Skyland Blvd. East, Tuscaloosa, AL 35405. I cannot be issued a replacement until I have complied with this paragraph.

LOST - If I lose my TDD or specialized telephone access equipment, I must report the loss to AIDB-Tuscaloosa Regional Center, 2412 Skyland Blvd. East, Tuscaloosa, AL 35405. I understand I will not be issued a replacement if original equipment is lost.

FALSE STATEMENT LIABILITY - I understand that it is against the law to file false statements regarding loss, damaged or stolen State property. I understand that false statements filed by me can result in my being criminally prosecuted. I understand that if I sell or pawn my equipment, I can be criminally prosecuted. I understand and agree to defend, indemnify and hold harmless the State of Alabama, The Alabama Public Service Commission, the Alabama Institute for Deaf and Blind and its regional centers, units, agents, agencies, departments, officials, representatives and employees from any and all claims, damages and expenses of whatever nature arising out of use or misuse of the equipment given to me for personal use either by me or any person. I further understand and agree that the State of Alabama, The Alabama Public Service Commission, the Alabama Institute for Deaf and Blind and its regional centers, units, agents, agencies, departments, officials, representatives and employees are not responsible for equipment furnished by the supplier of the equipment, for any acts of omissions of the supplier of the manufacturer of the equipment. Any claims or disputes over the equipment or maintenance of the equipment may be asserted solely against the supplier of manufacturer of the equipment. The State shall not be considered a seller of the equipment and shall not be considered in any way a party to any transaction (s) between the customer and the supplier or manufacturer of the equipment.

EQUIPMENT - Failure to comply with these Conditions of Acceptance will result in my being denied the privilege of having special telephone access equipment provided by the State of Alabama.

TRAINING - Upon approval of an application form, I may also attend a training class specific to the device I will receive. Upon my completion of training, the specialized telephone access equipment will be issued. If I am a minor, a parent/guardian will accompany me to the required training class to sign this statement.

PRINT NAME: _____

SIGNATURE: _____ **Date:** _____

(Applicant or parent/guardian, if under age 18)

WITNESS: _____ **Date:** _____

EQUIPMENT SERIAL NUMBER:

EQUIPMENT TYPE:
