

Detach and return to:

Kansas Telecommunications Access Program
4848 SW 21st Street, Suite 201
Topeka, KS 66604-4415

785-234-0200 (Voice)
785-234-0207 (TTY)
tap@kstelecom.com



Social Security Number

Personal Information
(to be completed by applicant)

Name _____
(Last) (First) (MI)

Address _____
(P.O. Box not permitted)

City _____ Zip _____ County _____

Home Phone (_____) _____ Date of Birth _____ / _____ / _____

- Yes No I am a resident of Kansas.
- Yes No I have telephone service at my place of residence.
- Yes No I have a disability/impairment that interferes with using the telephone.
- Yes No I have a household gross income that is less than \$55,000 per year.
(\$3,000 may be added for each dependent claimed).

Please check your disability(ies)/impairment(s):

- Blind/Vision Loss Cognitive Impairment Deaf/Hearing Loss
- Hearing and Vision Loss Mobility/Motor Impairment Speech Impairment

I verify under penalty of perjury that the above is true and correct.

Applicant or Guardian Signature _____ Date _____

(TAP reserves the right to request proof of documentation of income. Refusal to provide requested documentation will result in denial of your application).

Check only one: **Voucher Disbursement Information** *(to be completed by applicant)*

- I would like the TAP staff to order my equipment and have it sent to me.
- Please send the voucher(s) to me. I will order my own equipment.
- Please send my voucher(s) in care of the person listed below.
- Please order my equipment and send it in care of the person listed below.

Name Wilson Communications Phone (785) 658-2111

Address PO Box 190

City Wilson State KS Zip 67490

Equipment Information

(to be completed by applicant)

Check **ONE** box from **Category A**
and **ONE** box from **Category B**

Category A

- | | |
|--|--|
| <input type="checkbox"/> Amplified Cordless Telephone | <input type="checkbox"/> CapTel phone |
| <input type="checkbox"/> Amplified Corded Telephone | <input type="checkbox"/> Cordless Telephone (not amplified) |
| <input type="checkbox"/> Amplified Speakerphone | <input type="checkbox"/> Photo Button Telephone |
| <input type="checkbox"/> Emergency Response Telephone with Remote | <input type="checkbox"/> Speech Amplification Telephone |
| <input type="checkbox"/> Hands-Free Telephone (check accessory needed) | <input type="checkbox"/> Speech Amplification TeliTalk with Telephone |
| <input type="checkbox"/> Headset <input type="checkbox"/> Lapel Mic <input type="checkbox"/> Puff Switch | <input type="checkbox"/> TTY |
| <input type="checkbox"/> Hands-Free Telephone with In-Line Voice Dialer | <input type="checkbox"/> TTY with Large Visual Display (Superprint Pro 80) |
| <input type="checkbox"/> Help at Hand Emergency Telephone Dialer | <input type="checkbox"/> TTY (Braille) |
| <input type="checkbox"/> In-Line Voice Dialer | <input type="checkbox"/> TTY Modem/Card |
| <input type="checkbox"/> Large Button Telephone | <input type="checkbox"/> VCO/HCO Telephone (Uniphone) |
| <input type="checkbox"/> Large Number Amplified Telephone | <input type="checkbox"/> VCO/HCO Telephone (Dialogue) |
| <input type="checkbox"/> Large Number Telephone with Braille and Number Announcer | |

Category B

- | | |
|--|--|
| <input type="checkbox"/> No signaler needed at this time | <input type="checkbox"/> Loud Bell Ringer |
| <input type="checkbox"/> Light Flasher | <input type="checkbox"/> Tactile Signaler (Deaf/Blind only) |

Training

- I do not need training on my new TAP equipment.
- I will call the TAP office after I receive my equipment to schedule an appointment if training is needed.
I authorize TAP to give my name and phone number to a professional to contact me for training.

Disability Certification

(To be completed by one of the following)

All information must be completed.

I am a licensed:

- Audiologist
 Physician
 Ophthalmologist
 Optometrist
 Speech Pathologist
 Vocational Rehabilitation Counselor
 NO OTHER CERTIFYING AUTHORITIES ACCEPTED!

Please check the disability(ies)/impairment(s) being certified:

- Blind/Vision Loss
 Cognitive Impairment
 Deaf/Hearing Loss
 Hearing and Vision Loss
 Mobility/Motor Impairment
 Speech Impairment

Certifying Authority's Name (print clearly): _____

State License or Certification Number: _____

Address: _____ City: _____ State _____

Zip: _____ County: _____ Phone: (____) _____

I hereby certify that (applicant's name) _____
has a disability/impairment that requires specialized telecommunications equipment in order to effectively use the telephone.

Certifying Authority's Signature _____ Date _____

Please specify (if any) other basic telecommunications equipment needs not listed above: _____

Comments: _____