

**-APPLICATION FOR COMMUNICATIONS EQUIPMENT -**

**Return to: MTAP, PO Box 4210, Helena, MT 59604**

**Questions? Call 1-800-833-8503**

**GENERAL INFORMATION:**  **MALE**  **FEMALE**

**REQUIRED INFORMATION MARKED WITH \*\***

\*\* SSN \_\_\_\_\_ \*\*Birthdate: \_\_\_\_ / \_\_\_\_ / \_\_\_\_

\*\* Name: \_\_\_\_\_  
Last First MI

\*\* Street Address: \_\_\_\_\_  
Street City Zip

\*\* Mailing Address: \_\_\_\_\_  
RR, HC, PO Box City Zip

\*\* Land Line Phone # \_\_\_\_\_ \*\*Phone Service Provider \_\_\_\_\_

Cell Phone # \_\_\_\_\_ Cell Phone Service Provider: \_\_\_\_\_

Internet available? \_\_\_\_\_

E-Mail Address: \_\_\_\_\_

\*\* I am a Montana Resident (must be six months or more)  Yes  No

**Race/Ethnicity:** (Check all that apply):

- American Indian or Alaska Native
- Asian
- White
- Hispanic or Latino
- Native Hawaiian or Pacific Islander
- Black or African American

**Additional Contact information: Please do not list yourself**

Name: \_\_\_\_\_ Phone #: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ Zip: \_\_\_\_\_

Contact's Relationship to Applicant: \_\_\_\_\_

How did you hear about MTAP?

- Friend
- Family
- Newspaper
- Audiologist
- Internet
- Mailer
- TV
- SLP
- Phone Book
- Phone Company
- Presentation
- Facebook
- Radio
- Other \_\_\_\_\_

**\*\* DISABILITY AND EQUIPMENT INFORMATION**

**The applicant is (check all that apply):**

**NOTE:** Vision disability **MUST** be paired with one of the other listed disabilities to receive MTAP Services

- Deaf
- Deaf/Blind
- Visually Disabled
- Hard of Hearing
- Speech Disabled
- Mobility Disabled
- Deaf with Cochlear Implant

If Mobility Disabled, please describe: \_\_\_\_\_

If Hard of Hearing or Deaf, do you wear hearing aid(s)? \_\_\_\_\_, one or two hearing aids \_\_\_\_\_

List any other pertinent information regarding your disability: \_\_\_\_\_

**The applicant requests (check any that may apply):**

- Amplified Telephone
- Artificial Larynx
- Captioned Telephone
- Weak Speech Amplification
- "Hands Free" Speaker Phone
- I need MTAP to help me determine what equipment will work the best for me.
- TTY
- Loud Ringer
- Light Signaler (ring flasher)
- Mobile Device

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\*If you are **Deaf or Speech Disabled**, and are requesting an iOS device, please note what device you are requesting  iPad Air  iPad Mini  iPhone

\*\*If you are **Deaf**, sign language is required to be your primary mode of communication, if **speech disabled**, the name of a speech pathologist is required in the verifier information section below.

**\*\* INCOME INFORMATION Please provide a DOLLAR AMOUNT for income**

\*\* Total Number of Persons in Household: \_\_\_\_\_

\*\* Total Annual Household Net Income \$ \_\_\_\_\_, per year

Note: Participation in our program is based on household income along with the number of persons which that income supports (family size). To qualify, an applicant's family income must be lower than 250% of the current year's Federal Poverty Guidelines.

<https://dphhs.mt.gov/Portals/85/detd/documents/MTAP/GovCommittee/2019IncomeGuidelines.pdf>

**VERIFIER INFORMATION**

The **professional listed** below can verify my disability:

Note: Please **DO NOT list yourself, a relative, your pastor or your landlord.** A verifier can be any medical or hearing professional, a care-giver or social worker who can verify your hearing, speech or mobility disability.

**You do NOT need a signature from the verifier.**

\*\* Name: \_\_\_\_\_ Telephone: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ Zip: \_\_\_\_\_

**Verifier's Occupation (check one):**

- |  |  |
|--|--|
| <input type="checkbox"/> Licensed Physician                  | <input type="checkbox"/> Voc. Rehab. Counselor |
| <input type="checkbox"/> Hearing Aid Specialist              | <input type="checkbox"/> Speech Pathologist    |
| <input type="checkbox"/> Audiologist                         | <input type="checkbox"/> MTAP Staff            |
| <input type="checkbox"/> Other - Please Specify Other: _____ |  |

**CONDITIONS OF ACCEPTANCE FOR EQUIPMENT LOAN (IF ELIGIBLE):**

**Use and Care:** The equipment is for use with the telephone and no other purpose. I agree to protect the equipment against all damage. Any defective equipment, or equipment in need of repair, will be reported to MTAP and returned to the program immediately. I will not try to repair the equipment myself, or take it apart. MTAP will replace or repair equipment for qualified consumers.

**Theft:** If my equipment is stolen, I will report it to law enforcement within 24 hours of discovery. A copy of the theft report must be sent to MTAP within five (5) days of the date the theft was reported.

**Loss:** If I lose my equipment, I must report the loss to MTAP. I understand that I may not be issued a replacement.

**Change of Address:** If I move to another location within the State of Montana, I must notify the program of the new address within twenty (20) days after the date of the move. If I move out of the State of Montana, the equipment must be returned prior to the move.

**State Property:** Because my equipment is the property of the State of Montana, I will not sell, give or loan the equipment to anyone. I understand that if I sell or pawn my equipment, I can be criminally prosecuted.

**APPLICATION CERTIFICATION**

I have read the above conditions of acceptance and if loaned a device, I agree to comply with all conditions. I understand my failure to comply with all of these conditions will result in my being denied the privilege of having equipment provided by the State of Montana.

I certify under penalty of the offense of false swearing (Section 45-7-202, MCA), that I meet the definition of Deaf, Deaf/Blind, Hard of Hearing, Speech Disabled, or Motion/Mobility Disabled given on the application instruction sheet and that all statements made by me are true and correct to the best of my knowledge. I agree to inform the Montana

Telecommunications Access Program (MTAP) of any changes to this information as long as I am receiving services.

\*\* Applicant's Signature: \_\_\_\_\_ \*\* Date: \_\_\_\_\_

**Responsible Party Signature (if applicant is unable to sign):**

Signature: \_\_\_\_\_ Date: \_\_\_\_\_