



# Telecommunications Access Program

A Program of the Department of Workforce Education  
Arkansas Rehabilitation Services Division  
26 Corporate Hill Drive, Little Rock, Arkansas 72205  
501-686-9693 (V/TTY)  
Toll Free 1-800-981-4463 (V/TTY) FAX (501) 683-3011  
[www.arsinfo.org](http://www.arsinfo.org)  
**Application**

Companies are not eligible. Applicant must be an individual.

## Eligibility Requirements

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### *Arkansas Residency*

TAP serves only the residents of Arkansas. **Please initial the following:**

I certify that I am a legal Arkansas resident.

*Telephone Service (CAUTION: Equipment may or may not work with digital, cable or satellite service and/or may damage equipment.)*

I certify that I have phone service or personal telecommunication service and/or will have service within 30 days.

*If applying for equipment prior to obtaining service, you may be asked for further documentation before receiving equipment.*

### *Disability*

Send the Eligibility Certification form to one of the qualified professionals listed on the form to fill out and prove you have a disability. Then send the form back to TAP with your application.

**Writing must be legible. Failure to answer all questions may delay processing.**

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Forms are available in  
alternate formats upon request by calling TAP at 1-800-981-4463 (V/TTY)

**Return this form**

TAP-01: Revised 08/07

## Your Rights

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### 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, 1616 Brookwood Drive, Little Rock, Arkansas 72202 or call 1-800-330-0632 (V/TTY).

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TAP-01: Revised 08/07

## Specialized Telephone Equipment

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Following are examples of equipment available by types of disabilities. Please check the equipment you are requesting. TAP staff may assist you in finding equipment that meets your needs.

 **Do you need training?**                      **Yes**    **No**

If you need to be alerted the phone is ringing, please circle which you need.

**Visual**(flashing light) **Audible**(loud ringer) **Tactile**(vibration for deaf/blind) **Combo**(light/ringer)

### **Deaf**

\_\_\_ TTY (Teletypewriter): For sending and receiving typed messages.

### **Hard of Hearing**

\_\_\_ Amplified phone/speakerphone: Telephone with volume adjustment for incoming voice and louder than normal ringer.

\_\_\_ VCO Telephone: For outgoing spoken message and incoming typed message through a relay service.

\_\_\_ Uniphone: Combination text telephone and standard phone allowing for regular calls, TTY calls, voice or hearing carry over calls.

\_\_\_ Cordless or Cordless with Caller ID Telephone: Lightweight cordless phone with volume adjustment for incoming voice.

\_\_\_ CapTel Phone: for hard of hearing persons enabling them to use their speech for outgoing calls but receive captioned messages for incoming calls.

\_\_\_ Caller ID: amplified speakerphone with caller ID capabilities.

### **Deaf/Blind**

\_\_\_ TTY with Braille: For sending and receiving Braille messages.

\_\_\_ TTY with Large Visual Display: For persons who are deaf and have severe visual problems.

### **Speech Impaired**

\_\_\_ Artificial Larynx: Handheld, portable voice aid for people who have lost use of their larynx. (Specific artificial larynx must be recommended by the person who signs the Eligibility Certificate.)

\_\_\_ Speech Amplifier: Telephone or other device to increase the volume of the outgoing voice.

### **Blind/Vision Impaired**

\_\_\_ Amplified phone speaks each number as it is pressed - jumbo sized buttons with Braille

\_\_\_ Phone with volume control and larger than standard caller ID screen.

\_\_\_ Talking caller ID amplified phone with talking keypad.

### **Mobility Impaired**

\_\_\_ Hands Free Telephone: Speaker phone with optional headset and/or other special features.

\_\_\_ Cordless Telephone: Lightweight cordless telephone with volume adjustment for incoming voice.

### **Cognitively Impaired**

\_\_\_ Photo Phone: Telephone with nine large photo auto-dial memory buttons that you can put a picture in of the person you want to call.

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TAP-02: Revised 08/07

## Personal Information

Name of Applicant

Please print Last First M.I.

HomeAddress City Zip County

Mailing Address  
(If different from home address)

E-mail Address (if applicable)

Home Telephone Number ( ) (V/TTY/VP) Pager Address

High speed internet or DSL? Y/N Name of phone company/provider Caller ID service: Y/N

Social Security Number Male Female Date of Birth

Caucasian African American Hispanic Asian Native American Other

Usual method of communication: Sign Language Speech Written

Contact person (someone living at a different address)

Address Phone Number Relationship to you

### INCOME

Please list persons living with you:

Name	Relationship
_____	_____
_____	_____
_____	_____

Yearly adjusted gross income \_\_\_\_\_ Source of 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.

### HISTORY

Have you applied for TAP equipment in the past? Yes \_\_\_\_\_ No \_\_\_\_\_ If yes,when? \_\_\_\_\_  
(Re-application required every 3 years if asking for other equipment or sooner if TAP requests updated information.))

Are you an Arkansas Rehabilitation Services' client? Yes \_\_\_\_\_ No \_\_\_\_\_

How did you learn of the TAP program? \_\_\_\_\_

I certify under penalty of perjury that all statements made by me are true and correct to the best of my knowledge. I give permission to TAP to request more information for the purpose of verifying my need for special equipment.

*Note: If the applicant is a minor, then a parent or legal guardian must sign.*

Applicant's signature \_\_\_\_\_ Date \_\_\_\_\_

*Original signatures required. Make sure you answer all the questions. Sign your name and put the date.*

(OVER)

TAP

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TAP-02: Revised 08/07

## TAP Conditions of Acceptance

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(This is very important. Read it carefully, sign your name and date it.)

### A. Two (2) Year Equipment Loan

- 1) Remains the property of the state of Arkansas for two (2) years and then becomes the property of the recipient of the equipment. A person who receives the equipment shall be responsible for the maintenance of the equipment and liable to Arkansas Rehabilitation Services for the loss of or damage to the equipment.
- 2) You must cooperate and comply with inventory/follow up requests. If there is evidence of intentional abuse or neglect, TAP has the right to remove the equipment from your home.
- 3) Each applicant shall be eligible for up to two primary devices that provide access to telecommunication service and up to 4 alerting devices needed to access the telecommunications network (ie. Signaler and receiver either audible or visual).
- 4) Minor - Equipment responsibility will be transferred on their 18th birthday.
- 5) You must return equipment within 30 days if one of these things happen:
  - (a) Move to another state to live.
  - (b) If you lose telecommunication service and it is not reconnected within 90 days.
  - (c) No longer need or want it.
  - (d) Move to a facility where you do not have personal telecommunication service.
- 6) Change in Personal Situation
  - (a) Move - If within Arkansas, notify TAP within 10 days of a new address and telephone number.
  - (b) Must get permission from TAP if out of state more than 90 days with equipment.
  - (c) If 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).

### B. Your Responsibilities

- 1) Return the signed equipment loan contract within 30 days or TAP may ask you to return the equipment.
- 2) All extra materials including batteries, paper, light bulbs, artificial larynx accessories and other miscellaneous supplies.
- 3) Keep the equipment clean and protected (away from rain, heat, bugs, pets, liquid, sticky/greasy substances and excessive smoke from tobacco use).
- 4) You must use the equipment only for the intended purpose.

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Please Note: Signature required on second page.

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## TAP Conditions of Acceptance

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### C. Replacements

- 1) Exchanges may be made within 60 days. If asked, recipient must provide TAP updated information in order to receive more equipment.
- 2) Equipment may be exchanged if:
  - (a) It is stolen, damaged through natural disaster, or damaged by something out of your control. (A police or fire report must be sent to TAP.)
  - (b) It no longer meets your needs due to a change in your disability. (A new certification may be required and sent to TAP.)
  - (c) TAP will replace equipment that does not work (broken) or cannot be repaired due to normal wear and tear. Individual must still be approved by TAP and re-application may be necessary after the two year time period.

### D) Repairs

- 1) TAP is responsible for repairs of normal wear and tear on the equipment for two (2) years.
- 2) You must clean equipment before returning to TAP for repair.
- 3) During the two (2) year loan period, do not repair, take apart or modify your equipment. Contact TAP.
- 4) Loaner equipment may be available during repair.
- 5) If you abuse your equipment, you must pay all of the repair and/or shipping costs.

### E) Suspension (Four years from the date TAP found out you broke the rules.)

- 1) You will be suspended from TAP if you:
  - a) Sell, pawn, or give the equipment to someone else.
  - b) Damage equipment including misuse that voids the warranty or violates other parts of the rules.
- 2) You must keep equipment in your possession or face repossession, prosecution or liability for purchase price.

### F) Denial

- 1) It is against State law to file any false statements regarding my application, income, theft, loss or damage to the equipment. I understand if I don't follow these Conditions of Acceptance, I can be denied TAP equipment. I understand that I may also be criminally prosecuted.

**I have read and understand the Conditions of Acceptance:**

Signature \_\_\_\_\_

Date \_\_\_\_\_

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# Eligibility Certification

Take this form to one of the professionals listed below.

Applicant's name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

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

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: A cognitive impairment that prohibits use of a standard telephone.
- \_\_\_\_\_ Legally Blind: A visual loss of such severity that prohibits the use of a standard telephone; must rely on audible or Braille information.
- \_\_\_\_\_ Speech or Voice Impairment: Inability to speak intelligibly or use adequate voice on a standard telephone.  
(If specialized equipment is requested, the specific recommendation from the certifying professional must be included.)

Specify what kind \_\_\_\_\_

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

I am qualified to certify eligibility as: *(check one)*

- |  |  |
|--|--|
| Physician _____  | Ophthalmologist _____                              |
| Audiologist _____                                      | Optometrist _____                                  |
| Speech Pathologist _____                               | Arkansas School for the Deaf qualified staff _____ |
| Occupational Therapist _____                           | Division of Services for the Blind Counselor _____ |
| Physical Therapist _____                               | Arkansas Spinal Cord Commission Counselor _____    |
| Neuropsychologist _____                                | Home Health Professional _____                     |
| Arkansas Rehabilitation Services qualified staff _____ | Hearing Aid Dealer/Specialist _____                |
| Social Worker _____                                    |  |

I certify that 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 will probably benefit this person.

Signature of Certifier \_\_\_\_\_ Date \_\_\_\_\_

Print Name \_\_\_\_\_ Title \_\_\_\_\_

Street \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Telephone \_\_\_\_\_ License Number \_\_\_\_\_ Fax number \_\_\_\_\_