Application for the Nebraska Specialized Telecommunications Equipment Program

A. APPLICANT INFORMATION

(please print)

NAME: ____

(Last) (First) (Middle Initial)

HOME ADDRESS: ____

(Number and Street Name, or PO Box)

CITY: __________________________ **STATE**: ____________________________

ZIP:_____________________**COUNTY**: __________________________________

DAYTIME PHONE: ( ) _______________________**V/TTY/Both**

(circle one)

HOME PHONE: ( ) ___________________________**V/TTY/Both**

(circle one)

SOCIAL SECURITY NUMBER: __________-___________-__________

BIRTH DATE: ________/___________/____________

Name of someone who can help us contact you: (a person not living with you). NOTE: If mail address is different than the applicant's address, complete this section and check here:____ .

NAME: ______________________ **PHONE**: ( )_______________**V/TTY/Both**

(circle one)

ADDRESS: ____

CITY:__________________________**STATE**:_________**ZIP**:________________

B. EQUIPMENT NEEDS

Part 1 – Telephone Equipment – (Please Check Only One)

__ Computer Conversion Package (TTY modem only)

__ Phone with Amplification (Built-in)

__ Phone Amplifier

__ TTY/TT (with 6 rolls of paper maximum)

Additional application required:

___ Large Visual Display

___ Tactile Ring Signaler

___ Telebrailler

__ Voice Carry Over (VCO) Phone

Check if Setup is required:____

__ Other (please specify)____________________________________

Part 2 – Phone Signaling Devices – (Please Check Only One)

__ Light Signaler Phone Ring – Master

_________Number of remote receivers needed (Limit of 2)

__ Phone Ringer

__ Personal Vibrator

__ Other (What Kind – example, "Alertmaster")________________________

C. ELIGIBILITY

YES **NO**

__ __ I have a hearing, visual and hearing loss, or speech disability, which prevents me from using the telephone effectively.

__ __ I am three years of age or older, and can demonstrate the ability to use the equipment.

__ __ I now have phone service or have applied for phone service in the state of Nebraska at my place of residence.

__ __ I am a current resident of the state of Nebraska.

__ __ Have you ever applied for this program? If yes, approximate month and year _____/_____

The above facts are true and complete to the best of my knowledge.

X_______________________________DATE____________________

(*Applicant or Guardian's Signature if applicant is under 18 years of age)*

PROFESSIONAL CERTIFICATION

(to be completed by certifier)

I certify that this applicant as one of the following:

__ Deaf   __Hard of Hearing   __Speech Disability   __ Deaf-Blind

(check one of the following and provide appropriate information)

__ Assistive Technology Project Representative (ATP)
__Audiologist or Licensed Hearing Aid Dispenser
__Augmentative Speech Pathologist
__Center for Independent Living Representative
__Licensed Physician/Assistant
__Nebraska Commission for the Deaf and Hard of Hearing (NCDHH)
__Services for the Visually Impaired Representative (SVI)
__Speech Pathologist
__Vocational Rehabilitation Representative (VR)
__Other ____

This individual requires other adaptive equipment (specify): ___________

(please print)
NAME: ____

AGENCY NAME: ____

ADDRESS: ____

CITY: ______________________ **STATE:**_____________ **ZIP:** _____________

TELEPHONE: (   ) ________________**FAX: (   )** ________________________

E-MAIL ADDRESS: ____

X ____**DATE:**________________

(Certifier's Signature)   (Title)

INTERNAL USE ONLY

Approved ____ Denied____

Completed by:

NAME:______________________AGENCY:_______________________

ADDRESS:____

CITY:_______________________STATE:________Zip_______________

PHONE NUMBER: ( ) ____

E-MAIL ADDRESS:____

X__________________________________DATE:_____________________
(NSTEP Coordinator's Signature)