Telecommunication Adaptive Devices (TAD) Program

Application

APPLICANT INFORMATION

Name: _____Date of Birth:_____/_____/_____Age:_____

Street Address: _____ City/St/Zip: _____

County of Residence:_____ Email address: _____

Telephone Number: _____Cell Phone Number:_____

*Gender: ____Male ____Female

*Race: ___White ___Black ___Native American ___Hispanic ____Asian American ___Other

* Starred questions are optional at the discretion of the applicant. This information is used by the department for demographic program reviews.

ELIGIBILITY

To determine eligibility, please complete the following:

Are you a resident of the state of South Dakota? ____Yes ____No

Do you have access to telecommunication Service? ____Yes ____No

Type of telecommunication service that will be used (ex: home phone service, cellular service):

_____

DISABILITY

- To be eligible for the TAD program, the individual must have a disability other than deafness, deaf/blind, hard of hearing, or speech impairment.
- Please include documentation of the disability.

Description of disability: _____

_____

Explain how the disability prevents the applicant from utilizing telecommunication: _____

_____

_____

Check the disability group that best defines the applicant's disability:

____Mobility (*orthopedic, stroke, arthritis, other physical*)

____Cognitive/Intellectual (*stroke, traumatic brain injury, developmental disability, autism, etc.*)

____Visual Impairment (applicants identified as having a vision loss should be referred to SBVI)

____Other (please describe)_____

INCOME ELIGIBILITY ***Note:** the income section is only necessary if the applicant is receiving a device that costs $250 or more. Most telecommunication devices or emergency response phones fall under the $250 threshold. Income guidelines apply to all iDevices.

Income - Income eligibility is based on 300% of the most recent federal poverty guidelines and includes gross household income. Annual income includes gross wages, public assistance benefits, social security payments, pensions and unemployment compensation.

Total Number of members in household:_____

Type of Income	Annual Amount
Gross wages	
Self-Employment	
Social Security, SSI or SSDI	
Pensions	
Public Assistance	
Unemployment/ Worker's Compensation	
TOTAL	

2018 Federal Poverty Guidelines	
Family Size	**300%**
1	$36,420
2	$49,380
3	$62,340
4	$75,300
5	$88,260
6	$101,220
7	$114,180
8	$127,140

Please include documentation of the income listed. Acceptable documentation includes:

- Income or wage statements (Include at least three consecutive pay stubs or statements, or
- Most recent federal tax form (1040 Tax Return)

I affirm that the information provided is complete and correct to the best of my knowledge.

Signature of Applicant:_____ Date: _____

After completing please return this form to:
Katie Gran/Division of Rehabilitation Services
811 E 10th St Dept 21, Sioux Falls, SD 57103
Email: Katie.Gran@state.sd.us or fax: 605-367-5327

AGENCY USE ONLY

____Eligible: ____Ineligible

If ineligible, identify the reason for ineligibility:_____

I certify that the information on this application is complete and correct.

_____ _____/_____/_____ SBVI – WRIL - ILC – DL - NAAP
Signature of Approved Provider Staff Date Circle Your Agency

Equipment Provided (it is necessary to show the cost only if the device is purchased by the provider)

Type of Device	Description	Cost
Emergency Response System		
Large Button Phone		
Picture Phone/Dialer		
Remote Control Speakerphone		
iPad/ iPhone		
Other		
TOTAL		