Telecommunication Adaptive Devices (TAD) Application

Applicant Name: _____ Date of Birth: ____/____/____ Age: _____

Physical Address: _____

City/State/Zip: _____

County of Residence: _____ Email: _____

Primary Phone: _____Secondary Phone: _____

Gender: Male ☐ Female ☐

Race: Caucasian ☐ | Native American ☐ | Hispanic ☐ | Asian American ☐ |

African American ☐ | Other: _____

Who else can we contact to reach you?_____ Phone: _____

How Did You Hear About TAD? (Check All That Apply)

☐ Previous Applicant ☐ Family/Friend ☐ Medical Professional ☐ Internet Search

☐ Booth Event ☐ VR/SBVI Referral ☐ Other: _____

Do You Have Access to Telecommunication Services? ☐Yes ☐No

Type of service used: ___Landline ___Internet ___Cell Service ___Other: _____

DISABILITY ELIGIBLITY

For TAD consideration, diagnosis can't be Deafness, Deaf/Blind, Hard of Hearing, or Speech Impairment.
Please include documentation of the disability with application.

Diagnosis(es): _____

_____

Explain the need for a specialized telecommunication device: _____

_____

_____

_____

Check the category below that best defines the applicant:

☐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: _____

INCOME ELIGIBILITY

NOTE: Complete only if applying for a device over $500. Most telecommunication devices or emergency response phones fall under the $500. Income guidelines apply to all iDevices.

☐ Check if device is under $500 and does not require income eligibility.

Total Number of Members in Household:_____

Complete the table below with income information including ALL members of the household.

Type of Income	Annual Amount		2023 Federal Poverty Guidelines	
Gross Wages	$		Family Size	400%
Self-Employment	$		1	$58,320
Social Security: SSI or SSDI	$		2	$78,880
Pensions	$		3	$99,440
Public Assistance	$		4	$120,000
Unemployment/Worker's Compensation	$		5	$140,560
			6	$161,120
			7	$181,680
TOTAL	$		8	$202,240

Please include the following documentation showing income, if applicable:

- Income or wage statements including: pay statements, social security, unemployment, Public assistance or other statements verifying money received by the family. Include at least 3 consecutive 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.

_____ _____ _____

Date Applicant's Signature Guardian or Parent (if applicable)

Please return application and supporting documents by mail, email, or fax:

Division of Rehabilitation Services
811 E 10th Street Dept. 21 Sioux Falls, SD 57103

Email: Hailey.Bowers@state.sd.us
Fax: (605) 367-5327

AGENCY USE ONLY

☐ Eligible: ☐ Ineligible: identify the reason for ineligibility:_____

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

☐ SBVI – ☐ WRIL - ☐ ILC – ☐ DL

_____ _____/_____/_____

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		