

# 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 ELIGIBILITY

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	2022 Federal Poverty Guidelines	
		Family Size	300%
Gross Wages	\$	1	\$ 40,770
Self-Employment	\$	2	\$ 54,930
Social Security: SSI or SSDI	\$	3	\$ 69,090
Pensions	\$	4	\$ 83,250
Public Assistance	\$	5	\$ 97,410
Unemployment/Worker's Compensation	\$	6	\$ 111,570
		7	\$ 125,730
		8	\$ 139,890
<b>TOTAL</b>	\$		

**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  
1310 Main Ave S Ste. 102 Brookings, SD 57006

Email: [Shayna.Remund@state.sd.us](mailto:Shayna.Remund@state.sd.us)  
Fax: (605) 688-5497

**AGENCY USE ONLY**

Eligible:  Ineligible: identify the reason for ineligibility: \_\_\_\_\_

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

\_\_\_\_\_  
Signature of Approved Provider Staff                      Date                      SBVI – WRIL - ILC – DL  
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		
<b>TOTAL</b>		