Virginia Department for the Deaf and Hard of Hearing

TECHNOLOGY ASSISTANCE PROGRAM (TAP) APPLICATION

APPLICANT INFORMATION							
Last Name:		**First Name:**		**Middle Initial:**		**Birth date:**	
Application Type:		**Application Date:**		**Veteran Status:**			
Home Address:							
City:		**County:**		**State:**	VA	**Zip:**	
Email Address:							
Phone Numbers:	**Primary** ☐VP ☐Voice ☐ TTY		**Secondary** ☐VP ☐Voice ☐ TTY		**Other Contact Name/Number**		

PROOF OF RESIDENCY

(Please attach a CURRENT copy of <u>one</u> of the following documents)

☐ Deed or Lease	☐ VA Driver's License or DMV ID	☐ Voter's Registration Card	☐ Utility bill

INCOME ELIGIBILITY

(<u>NOT</u> required for Veterans or Applicants using Pay Coupon)

☐ Pay Coupon Applicant (***Income information <u>not</u> required***)

Family Gross Income: (All sources before taxes) ☐ Annual ☐ Monthly		$	**Total Family Size:** (Including yourself)
Documentation Provided:	☐Bank statement/W2	☐ Income Award letter	☐ Other- Specify below (VDDHH approval required)

APPLICANT ACKNOWLEDGEMENT AND SIGNATURE

I understand and agree that:

1. All information provided above is accurate.	5. VDDHH is not responsible for my telephone or internet bill.
2. Providing false information may result in denial of my TAP application and any equipment issued must be returned.	6. I accept responsibility for the equipment, including repairs and maintenance costs.
3. If I move before I receive my equipment, I will inform VDDHH of my new address.	7. All equipment issued has a minimum one (1) year warranty. Some devices have longer warranties (Specialist can provide more details).
4. My personal information may be shared with D/HH Specialists for equipment delivery.	8. If I do not qualify for equipment at no cost, I have the option of paying the state contracted cost for equipment.

SIGNATURE OF APPLICANT (parent/guardian if applicant is < 18 years of age)	**DATE**
Relationship to Applicant (if applicable):	

APPLICANT TAP EQUIPMENT SELECTION
(To be completed by Certifier)

Alerting device:		**CAPTIONED TELEPHONE:**	
Alerting device accessory:		**CELL PHONE ACCESSORY:**	
Amplified telephone:		**OTHER:**	
Assistive listening device:		**TTY:**	

CERTIFICATION OF TAP ELIGIBILITY
(To be completed by Certifier)

I certify that this TAP Applicant is:	☐ Deaf	☐ Deaf-Blind	☐ Hard of Hearing		
	☐ Other *(Specify)*		☐ Person w/ difficulty speaking		
In accordance with TAP Regulations, I am eligible to certify this application as a/an:	☐ D/HH Specialist	☐ Audiologist	☐ Doctor	☐ Speech Language Pathologist	☐ DBVI Specialist
	☐ Hearing Aid Specialist	☐ DARS Counselor	☐ Other *(Specify)*		

Certifier's Name:		**Certifier's Title:**	
State License #: (if applicable)		**Agency:**	
Address:			
Phone Number:			

SIGNATURE OF CERTIFIER	**DATE**