TELECOMMUNICATIONS
ACCESS IOWA

Application for Equipment

Please PRINT your answers to all of the questions completely.

Name of Applicant _____ _____ _____
First Name MI Last Name

Last 4 of Social Security # xxx-xx- _____ Birthdate ___/___/_____ Email _____

Home Phone (_____)_____ ☐ Voice ☐ Text ☐ VP Alternate Phone (_____)_____ ☐ Voice ☐ Text ☐ VP

Street Address _____ Apt/Unit # _____
(PO Box Number not accepted here; see below to add mailing address if necessary)

City _____ , IA Zip _____ County _____

I am assisting the applicant with completing this form (optional). It also can be the applicant's PO Box, a relative, or authorized care provider of the Applicant.

Name _____ Relationship to Applicant _____

Address _____ Email _____

City, State, Zip _____ Phone (_____)_____

How did you learn about this program?

☐ Hearing Specialist/Audiologist/Speech Pathologist ☐ Friends/Family ☐ Senior Living/Long Term Care ☐ Mail from TAI ☐ TV/Radio/Newspaper
☐ Physician/Nurse/Caretaker/Healthcare ☐ State Agency ☐ Website/Social Media ☐ Presentation/Exhibit Booth ☐ Other _____
Event name?

Do You Qualify?

YES	NO	Answer all the questions below:
☐	☐	Do you live in Iowa?
☐	☐	Are you older than 5 years of age or able to use the telecommunications equipment?
☐	☐	Do you have telecommunications service in your home now or are you going to get service hooked up?
☐	☐	Would the telecommunications equipment you are asking for make telecommunications use easier for you?
☐	☐	Is your annual adjusted gross income less than what is listed on the chart? →

Annual Total Family Income

1 person	$66,000
2 persons	$76,000
3 persons	$86,000
4 persons	$96,000

(add $10,000 for each additional person)

Your Signature Required

By my signature below, I certify that all of the above information is true. By signing this application form, I agree to participate in any follow up survey in order to assure quality customer service and satisfactory use of my equipment. I understand that I am only allowed to receive one item or package of items every three years. I become the owner of the items I receive and am responsible for the maintenance and warranty. I agree to pay any remaining cost that is not covered by the Telecommunications Access Iowa Voucher Program.

X _____ Date _____
ORIGINAL Signature of Applicant

X _____ Date _____
ORIGINAL Signature of Parent/Guardian, if applicant is under 18

_____
PRINTED NAME of Parent/Guardian **& Relationship** to applicant, if other than voucher recipient

FOR MORE INFO, VISIT
www.teleiowa.com/apply

IOWA | Iowa Utilities Commission

See next page for equipment selection and signature. →

Equipment Needed

For detailed information on each piece of equipment, use the QR code on the first page or visit www.teleiowa.com/apply. You can choose one phone, but applicants may also select a separate Headset or Neckloop, Phone Ringer/Signaler and/or an Amplified Answering Machine, if desired.

TELEPHONES (choose up to 1)

- ☐ Enhanced Amplified Phone
  includes corded/cordless over 35 dB ampli ication; most models include bulit-in answering machine; some have speech amplification
- ☐ Captioned Telephone
  CapTel, built-in answering machine
- ☐ In-Line Device Amplifier
- ☐ Bluetooth Amplifier
- ☐ Electrolarynx Telephone Kit

ACCESSORIES (choose up to 3)

- ☐ Headset
  Choose one of these two options
- ☐ Neckloop

_____

- ☐ Loud/Flashing Ringer
  Choose one of these two options
- ☐ Tactile Ringer

_____

Headset or Neckloops work with amplified phones, captioned telephones, & speech amplified phones.

Select a separate Phone Ringer/Signaler, if desired.

For equipment or accessory that is not listed, or assistance in selecting an equipment vendor, contact TAI at **800-606-5099.**

Equipment Vendor

Once qualified, a voucher will be emailed directly to your selected equipment vendor. The equipment vendor will contact you to process your order and send you your telecommunications equipment. Write down the equipment vendor's name, address, and city. For a full list of vendors, visit **www.teleiowa.com/vendors**.

Equipment Vendor Name _____

Address _____

City/State/Zip _____

Professional Signature Required

You must receive a signature by your doctor, audiologist, voc rehab counselor, state or federal agency representative, or any other licensed professional in the field of hearing or speech. Their signature verifies you have a need for specialized telecommunications equipment to assist communication over the telephone.

I certify that this applicant _____ needs the specialized telecommunications equipment selected because s/he is or has: ☐ Deaf ☐ Hard of Hearing ☐ Speech Difficulty

ORIGINAL Signature of Professional X _____ Date _____

Required to complete application

State License # _____

Printed Name of Professional _____

Occupation: ☐ Audiologist/Hearing Aid Specialist ☐ Speech Pathologist ☐ Doctor/Nurse ☐ Federal/State Agency Representative ☐ Teacher ☐ Other Licensed Professional _____

Agency Name _____ Phone (_____) _____

Address _____

City/State/Zip _____

MAIL OR EMAIL THIS FORM TO:

Telecommunications Access Iowa • 6925 Hickman Road • Des Moines, Iowa 50322 | info@teleiowa.com

Telecommunications Access Iowa is a statewide program of the Iowa Utilities Commission and administered by Deaf Services Unlimited, Inc. in Des Moines, Iowa.

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