Applicant Name_____

State of Rhode Island
Department of Human Services
Office of Rehabilitation Services

Adaptive Telephone Equipment Loan (ATEL)Program

40 Fountain Street ~ Providence, RI 02903
401-486-3325~ 401-222-3574 FAX ~ TTY (401) 222-1679

CERTIFICATE OF DISABILITY

To be completed by one of the following: a physician, an audiologist, a speech pathologist, a rehabilitation counselor of the Office of Rehabilitation Services (ORS) or a teaching staff member of the RI School for the Deaf (only if the applicant attends, or has attended the school).

Note to Professional: The above-named applicant is seeking verification of his/her disability to qualify to receive an adaptive telephone device from the State of Rhode Island. Three disability groups are served: speech disability, hearing loss or deaf, and the neuromuscular disability (anyone unable to dial or hold a receiver), **VISION LOSS ALONE**, is not a covered disability.

Disability (Please choose one):

☐ Deaf ☐ Hard of Hearing ☐ Deaf-Blind ☐ Hard of Hearing-Visual Disability

☐ Speech Disability_____.

☐ Neuromuscular Damage or Disease (Please specify i.e. MS, Parkinson's, Severe arthritis, etc.) _____.

1. Please give a brief description of the disability and how it affects telephone usage (i.e. hearing loss-would benefit with the use of an amplifier; aphasic – Can understand conversation but cannot speak; or neuromuscular disorder – Cannot dial phone, but can speak and hear conversation, etc.)

_____

_____.

2. If the applicant is requesting a specific iPhone/iPad App. Please provide name of App and reason for request.

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_____

I hereby certify that the above-named individual has a disability that restricts his/her use on a standard telephone. The information on this form is accurate and complete to the best of my knowledge. I understand that any attempt to provide fraudulent information will result in prosecution.

_____ _____
Office or Agency Name Signature of Professional

_____ _____
Address Printed name of Professional

_____ _____ _____
City, State and Zip License # Telephone #

PLEASE RETURN FORM TO THE ABOVE ADDRESS

Do not write below this line. For office use only. Date Received_____