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

ATEL APPLICATION FOR LANDLINE/HOME DEVICES

Name_____
(First) (Middle Initial) (Last)

Address_____
(Street) (Apt #)
_____RI_____
(City) (State) (Zip Code)

Telephone # (401) _____ Cell phone #_____

Last 4 digits of your SS# _____ Date of Birth _____/_____/_____

Do you have WIFI? ☐ no ☐ yes, email address: _____

Who is your home telephone service provider? _____

How do you get your messages? ☐ voicemail ☐ answering machine ☐ none

Have you or anyone in your household been issued equipment from the ATEL program?

☐ yes ☐ no

Who should we contact to set up appointment/delivery?

☐ myself ☐ alternate name_____

Relationship_____ Daytime telephone_____

HOW WOULD YOU LIKE TO RECEIVE YOUR EQUIPMENT?

SELECT ONE

☐ As soon as possible, please Fed Ex equipment

☐ I am unable to install the telephone devices, and would like to wait approximately **3-4 weeks for a home visit**; depending on length of waiting list and equipment availability. Appointments are scheduled (between 9-4, in a 2-3-hour time slots).

Do not write in this box. For office use only.

Case Number_____ Date Received_____

SELF IDENTIFIED DISABILITY

You must be Deaf, Hard of Hearing, Deaf-Blind, Hard of Hearing and Visual Disability, Speech Disabled or have a neuromuscular disability to qualify for the ATEL Program.

SELECT ONE

- ☐ Deaf
- ☐ Hard of Hearing
- ☐ Deaf-Blind
- ☐ Hard of Hearing AND Visual Disability (may not be vision disability only)
- ☐ Speech Disabled_____
- ☐ Neuromuscular Disability (such as MS, Parkinson, Rheumatoid Arthritis, Paralyzation) _____

LANDLINE/HOME TELEPHONE DEVICE SELECTION

The ATEL Program can only issue **ONE** device per household.

SELECT ONE

- ☐ Simple big button amplified telephone
- ☐ Simple big button amplified telephone WITH answering machine.
- ☐ Cordless amplified telephone.
- Cordless amplified telephone WITH answering machine.
- ☐ Captioned telephone (Deaf and Hard of Hearing that need to read their conversation, **INTERNET REQUIRED**)
- ☐ Hands free Speakerphone (unable to hold/dial standard telephone)
- ☐ Speech device- (low speech/need outgoing amplification).
- ☐ Speech device- (no speech/need to type my conversation).
- ☐ I would like an emergency 911 device, there is no monthly fee.
- ☐ Not sure, would like assistance with deciding.

A. APPLICANT INCOME GUIDELINES

Either applicant's gross household income must be less than 250% of the poverty level to qualify for the program. Gross household income includes wages, Social Security and/or pension income if applicable, or applicant must participate in a qualifying program.

Please check all boxes that apply:

☐ I meet the income requirement below.

My family size: ____ Yearly Gross Household Income is: _____

Size of Family	Eligibility Guidelines/ 250% poverty level		
1	$31,900	$2,658	per month
2	$43,100	$3,592	per month
3	$54,300	$4,525	per month

☐ I receive one of the qualifying program(s), please circle all that apply:

- food stamps, Medicaid, SSI, heating assistance, rite care, family independence program, general, public assistance, RIPAE (assisting tiers 60% &30%) or telephone lifeline service.

☐ I am **not eligible** but would like information on other available resources.

REQUIRED DOCUMENTS

Proof of Eligibility

- ✓ Either provide income verification or copy of eligibility card/letter that proves acceptance/participation in eligible low income program.

Proof of Disability included with application

- ✓ Signed certificate of disability to be completed by one of the following: 1) a doctor, 2) a speech pathologist, 3) an audiologist, 4) a rehabilitation counselor of the Office of Rehabilitation Services (ORS), or 5) A teaching staff member of the RI School for the Deaf (only if the applicant attends, or has attended the school).

I understand that this information will be kept confidential and will only be used as required for assistance, reports and audits. My signature below authorizes the ATEL program to contact my telephone carrier to verify service. I hereby certify that all statements made by me in this application form are true and correct to the best of my knowledge and belief. As long as I am receiving services, I agree to notify the agency if there is any change of the information furnished on this form.

_____ _____

Signature of applicant Date

_____

Printed name, and if not applicant, relationship to applicant

(Parent or guardian should sign if under 18 years of age)

PLEASE MAIL YOUR APPLICATION AND ALL REQUIRED DOCUMENTS TO:

Department of Human Services
Office of Rehabilitation Services
ATEL Program, 5TH Floor
40 Fountain Street,
Providence, RI 02903

Applicant Name_____

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

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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.

_____

_____

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_____