GA TEDP APPLICATION

A. APPLICANT

Full Name _____

Phone Number _____ ☐ Home ☐ Cell ☐ VP

Address _____ Apt. No. _____

Email Address _____

City/State _____

Zip Code/County _____

Birthdate ___/___/___

Marital Status ☐ Single ☐ Married ☐ Widowed

Number of Dependents (If Applicable) _____

B. RELEASE OF INFORMATION

I hereby request and authorize the followingcontact to provde/obtain information on my behalf to/from GATEDP.

Contact Name _____ Contact Number _____ Relationship _____

Contact Name _____ Contact Number _____ Relationship _____

All information I hereby authorize to be provided/obtained to/by the above will be held strictly confidential.

X _____ Date _____

Applicant Signature

LIST OF EQUIPMENT

The following is a list of equipment that we provide through GATEDP. You may select one telelphone and one accessory. For pictures and more information, please ask your Outreach Specialist or contact our office directly.

Captioned Telephones

- ☐ CapTel 840+ (no internet connection required)
- ☐ CapTel 840i (internet connection required)

Alerting Devices

- ☐ Alertmaster AL10
- ☐ Home Aware HA360

Amplified Telephones

- ☐ Clarity XLC 3.4 (no voicemail)
- ☐ Clarity XLC 8 (voicemail)
- ☐ Clarity Alto

Wireless Devices

- ☐ BeHear SMARTO
- ☐ Clarity XLCgo

Devices with Video Relay Service Capabilities (one per applicant)

- ☐ iPhone (VRS Users Only)
- ☐ iPad (VRS Users Only)

Other (to be filled out by Outreach Specialist)

- ☐
- ☐

Speech Equipment

For more information on Speech equipment, please contact our office and/or visit our website: gcdhh.org/gatedp.

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C. CERTIFICATE OF NEED (to be completed by a professional)

I am a/an: (Check all that apply)

- ☐ Audiologist
- ☐ Hearing Aid Specialist
- ☐ Senior Center Director
- ☐ Disability Service Center Director
- ☐ Doctor/Physician
- ☐ Physician's Assistant
- ☐ State Certified Teacher of the Deaf
- ☐ Nurse Practicioner
- ☐ Vocational Rehabilitation Counseler
- ☐ Social Worker
- ☐ Certified Therapist

Full Name _____ Phone Number _____

Address _____ City _____ State _____ Zip Code _____

Email Address _____ Fax Number _____

Check the disability being verified:

- ☐ Deaf
- ☐ DeafBlind
- ☐ Low Vision/Blind with Hearing Loss
- ☐ Late-Deafened
- ☐ Deaf with Low Vision
- ☐ Hard of Hearing

I assert to my qualification that I am authroized to verify the individual mentioned above has a hearing loss that prevents or limits their ability to use a standard telephone.

X _____ Professional's Signature

Date _____