State of Rhode Island and Providence Plantations
Department of Human Services
Office of Rehabilitation Services

Adaptive Telephone Equipment Loan (ATEL) Program

40 Fountain Street ~ Providence, RI 02903
401-462-7857 ~ 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?

☐ myself ☐ alternate name_____

Relationship_____ Daytime telephone_____

HOW WOULD YOU LIKE TO RECEIVE YOUR EQUIPMENT?

SELECT ONE

☐ As soon as possible, myself or a family/friend is available to pick-up the equipment, when notified by the ATEL office that the equipment is available at –
The Department of Human Services, 40 Fountain St, Providence (8:30-4, M-F).

☐ As soon as possible, myself or a family/friend is available to pick-up the equipment, When notified by the ATEL office that the equipment is available at –
TechACCESS, 110 Jefferson Blvd, Warwick (8:30-4, M-F).

☐ I do not have anyone available to pick-up the phone, 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-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-Visual Disability
- ☐ 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
- ☐ Cordless amplified telephone.
- ☐ Captioned telephone (Deaf and Hard of Hearing with poor speech discrimination)
- ☐ Hands free Speakerphone (unable to hold/dial standard telephone)
- ☐ Speech device- I have low speech/I need outgoing amplification.
- ☐ Speech device- I have no speech/I need to type my conversation
- ☐ Speech device other-_____
- ☐ I would like an emergency 911 device, there is no monthly fee.

APPLICANT INCOME GUIDELINES 2016

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 receive one or more of the following: food stamps, Medicaid, SSI, heating assistance, rite care, family independence program, general public assistance, RIPAE (assisting tiers 60% &30%) or telephone lifeline service.

Size of Family	Eligibility Guidelines/ 250% poverty level		
1	$29,700	$2475	per month
2	$40,050	$3338	per month
3	$50,400	$4200	per month
4	$60,750	$5063	per month

The Applicant's Family size: _____

Yearly Gross Household Income is: _____
and/or

The Applicant receives which above qualifying program(s): _____

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