



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 WIRELESS DEVICES

Name _____
 (First) (Middle Initial) (Last)

Address _____
 (Street) (Apt #)

 (City) RI (State) (Zip Code)

Telephone # (401) _____ Cell phone # _____

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

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

Have you or anyone in your household been issued equipment from the ATEL program?
 no yes

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.

- Deaf
- Hard of Hearing
- Deaf-Blind
- Hard of Hearing-Visual Disability
- Speech Disabled _____
- Neuromuscular Disability (such as MS, Parkinson, Rheumatoid Arthritis, Paralyzation) _____

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

Case Number _____ Date Received _____

A. WIRELESS SELECTION

You can choose from an iPad, iPhone or Jitterbug. .

The ATEL program provides the wireless device ONLY.

- If you select a Jitterbug, it is your responsibility to **PAY FOR ACTIVATION FEES** and **YOUR MONTHLY SERVICE PLAN**. You must contact Greatcall ONLY to activate Jitterbug 866-482-1424 and select your service plan.
- If you select an iPhone, it is your responsibility to **PRESELECT** your wireless provider, and **YOU MUST PAY FOR MONTHLY SERVICE PLAN**. Once a wireless provider has been selected, it cannot be changed.

Please select **ONE** device below.

1. Jitterbug Flip
- 1GB -Height: 4.3" Width: 2.2" Weight: 4.7 ounces Easy to use cell phone with big buttons, Easy to navigate with YES/NO buttons, Voice Dial, Hearing Aid Compatibility M4/T4 Rating.
2. Jitterbug Smart
- 8GB -Height: 6" Width: 3.1" Weight: 6.1 ounces (without required case) Easy to use smart phone with large icons, Voice typing, Hearing Aid Compatibility M4/T4 Rating.
3. iPad Air
- 32GB -Height: 9.40" Width: 6.6" Weight: 0.98lbs (without required case)
4. iPad Mini
- 32GB -Height: 7.87" Width: 5.3" Weight: 0.67lbs (without required case)
5. Apple iPhone® 7
- 32GB 4G -Height: 5.44" Width: 2.64" Weight: 5.04 ounces (without required case) Hearing Aid Compatibility M3/T4 Rating.
6. Apple iPhone® 7 Plus
- 32GB 4G -Height: 6.23" Width: 3.07" Weight: 6.77 ounces (without required case) Hearing Aid Compatibility M3/T4 Rating.
 - Please note that if you are hard of hearing and will be utilizing the Hamilton Relay App for caption telephone calls, you need to select a carrier that provides data and voice simultaneously.
 - Preselected Wireless Provider: ___ AT&T ___ Sprint ___ T-Mobile
___ Verizon ___ Other: _____

Please keep in mind that due to limited ATEL Program funds and the significant expenses of the iPhone/iPad, these wireless devices are on a first come first serve basis, and will be restricted to a yearly allocation, and then be placed on a waiting list for the following year; however, the Jitterbug wireless devices will not be subjected to these restrictions.

B. ADAPTIVE TELEPHONE EQUIPMENT LOAN PROGRAM (ATEL) PURPOSE

The primary purpose of the ATEL Program is telecommunications and the secondary purpose is communications. By checking below, you attest that you will use the iPad/iPhone for the specific purposes of the ATEL Program. Failure to complete this application area will lead to the application being denied, and falsification of information will lead to the device being recalled by the ATEL Program.

By **initialing** to the right, I attest that I understand and agree to comply with the **purpose** of the ATEL Program.

C. ADAPTIVE TELEPHONE EQUIPMENT LOAN PROGRAM (ATEL) CRITERIA

The below boxes define the criteria of how the wireless device can be used under the purposes of the Telecommunications Equipment Distribution Program. Please check **ALL** that apply.

- By checking this box, I will use the wireless device to access communications via **email**.
 - By checking this box, I will use the wireless device to access communications via **voice call and/or texting. For example: iMessage or Messages.**
 - By checking this box, I will use the wireless device to access telecommunications via **Video Relay Service (VRS.)** For example: Convo, Purple P3, Sorenson nTouch, ZVRS.
 - By checking this box, I will use the wireless device to access telecommunications via **IP Captioned Telephone Service (IP CTS.)** For example: ClearCaptions, Hamilton Cap-Tel.
 - By checking this box, I will use the wireless device to access telecommunications via **Video Calls.** For example: FaceTime, ooVoo, Skype.
 - By checking this box, I will use the wireless device to access telecommunications via **Voice Over Internet Protocol (VoIP) telephone service.** For example: Google Voice
 - By checking this box, I will use the wireless device to access telecommunications via **Alternative Augmentative Communication applications.** For example: Proloquo2Go, iSpeech TTS.
 - By checking this box, I will use the wireless device to access communications via **speech generating applications.** For example: Dragon Dictation.
 - By checking this box, I will use the wireless device to access communications via **specifically designed to be used directly by individuals with physical or mobility disabilities for their specific needs.** For example: A Special phone, Yes/No from I Can Do Apps
- If you are requesting a specific App(s). Please identify the App(s) and the reason for the request. If there is a cost to the App you will have to have 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) sign off on this request on your certificate of disability form.

By **initialing** to the right, I attest that I understand and agree to comply with the criteria of the Adaptive Telephone Equipment Loan (ATEL) Program.

D. 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): _____

E. 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 Telephone or Internet Service included with application

- ✓ Provide a copy of a recent landline or wireless telephone bill showing the applicant's name. If the telephone bill is not in the applicant's name, provide a copy of the bill and a statement from the account holder acknowledging the applicant has access to the telephone line.

Proof of RI Residency included with application

- ✓ Provide a copy of your Rhode Island Driver's License, State ID Card, gas, electric or water bill. NOTE: Bill MUST have applicant's name and current street address (no PO Box).

Proof of Disability included with application

- ✓ Signed certificate of disability.

I understand that this information will be kept confidential and will only be used as required for assistance, reports and audits. 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