

Applicant Name \_\_\_\_\_



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

**CERTIFICATE OF DISABILITY**

To be completed by one of the following: a physician, an audiologist, a speech pathologist, a rehabilitation councilor 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 in order 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), but could also have a vision loss, as long as it is in conjunction with 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 \_\_\_\_\_