

**Office for Deaf and Hard of Hearing Services
Application for Specialized Telecommunications
Assistance Program (STAP)
Speech Generating Devices**

Step 1—Provide Applicant Information

Applicant's first name:		Middle name:		Last name:	
Street address (PO Box is not acceptable):			City:		State: ZIP code:
Home telephone number:		Alternate telephone number:		Social Security number:	
TX driver's license number:		Birth date:		Email:	

Parent or legal guardian name:

Mailing Address (if different from above)

Name:					
Address:			City:		State: ZIP code:

If you provide a **different mailing address**, or a **parent or guardian signs** the application, select one:

- Applicant (PO Box) Guardian or family member

Specify the person's relationship to the applicant:

Signature. Unless the applicant signs the application or provides proof of residency in the applicant's name, the same person must both sign the application and provide proof of residency. This application must have an original signature—not a photocopy, facsimile, or stamped signature. If you are less than 18 years old, the parent or guardian must sign the application.

The following statement must be signed before the application can be processed.

I attest to the following:

- The applicant is a Texas resident.
- The applicant requires a specialized adaptive device(s) to access the telephone network.
- The device selected will enable the applicant to access the telephone network.
- I understand that STAP may request additional documentation as needed to confirm or supplement any information provided on the application, including physician's statements or medical records.
- All information given on this application is true.

Signature of applicant, parent, or legal guardian:		Printed name:		Date:
--	--	---------------	--	-------

**Mail to: STAP, PO Box 12607, Austin, TX 78711
This application form is valid until August 31, 2010
www.dars.state.tx.us/dhhs**

Step 2—Provide Proof of Residency

Include a copy of one of the following as proof of your Texas residency:

- Texas driver's license • ID card with address • utility bill (showing address) • Medicaid ID
- voter registration card • vehicle registration card • Medicare Summary
- letter on the official letterhead of a residential facility signed by the director or supervisor

Proof of residency **must** name the **applicant, parent, or legal guardian** signing the application **and** show the home address.

Step 3—Select Device

You must meet the established disability requirements for the device requested. Note: these disability requirements are defined in the form instructions.

SI = Speech impaired **CI** = Cognitively impaired
UMI = Upper mobility impaired **LMI** = Lower mobility impaired

Telecommunication Device or Software	Disability Requirements
Select the device needed:	
<input type="checkbox"/> ACD may include Augmentative Software Generates digitized or synthesized speech using pictures or text.	(SI and CI) or (SI and UMI)
<input type="checkbox"/> ACD Switch A device that connects to an ACD to allow the user to review and make selections.	SI and UMI
<input type="checkbox"/> ACD Head Pointing or Movement Control Device A device that connects to an ACD to allow access to an ACD using head or other body movements.	SI and UMI
<input type="checkbox"/> ACD Eye Control Access A device that connects to an ACD to allow access to an ACD using eye movements.	SI and UMI
<input type="checkbox"/> ACD Mount A device used to secure an ACD to a wheelchair.	(LMI and SI and CI) or (LMI and SI and UMI)
<input type="checkbox"/> ACD Switch Mount A device used to secure an ACD switch to a wheelchair.	(LMI and SI and CI) or (LMI and SI and UMI)
<input type="checkbox"/> ACD Moisture Guard A protective moisture barrier for an ACD device.	(SI and CI) or (SI and UMI)
<input type="checkbox"/> ACD Key Guard A protective overlay that helps prevent inadvertent key activation.	(SI and CI) or (SI and UMI)
<input type="checkbox"/> ACD Phone Compatible Attachment A device that enables an ACD to receive and make calls (including cords, cables, and kits)	(SI and CI) or (SI and UMI)
<input type="checkbox"/> Infrared Telephone A phone that can be operated by infrared transmitted signals.	SI and UMI
<input type="checkbox"/> Infrared Phone Switch A transmitting device that can be used to operate an infrared phone.	SI and UMI
<input type="checkbox"/> ACD Wireless Card and Software A device that enables an ACD to make and receive calls through a wireless service.	(SI and CI) or (SI and UMI)
<input type="checkbox"/> Anti-Stuttering Device Provides the user with Delayed Audio Feedback (DAF) and Frequency Shifted Audio Feedback (FAF).	SI
<input type="checkbox"/> Speakerphone A phone with a speaker built into the base.	SI or UMI or CI

Step 4—Provide a Professional Certification of Your Disability

A licensed speech-language pathologist must complete this section. Additional documents to supplement the pathologist's response may be attached. Print clearly. Illegible information may be returned for clarification.

Applicant's name:

Application number (for DHHS use only):

1. Specify manufacturer and product name of device requested:

2. Accessories or additional items requested:

3. Is a mount for ACD necessary? Yes No

Mount for switch? Yes No

4. Describe the severity of the applicant's speech impairment.

5. Is the applicant reapplying for a voucher because of a change of disability? Yes No

If yes, DARS3926, Change of Disability, must be completed. Contact stap@dars.state.tx.us for this form.

6. The applicant's impairment is: Temporary Stable Progressive

7. Describe equipment and procedures used to establish the need for the requested equipment. Include the names of all devices that were tested during the evaluation even if they are not being requested.

Augmentative Communication Device Request (Optional)

If an augmentative communication device is requested, the certifier must complete questions 8–12.

8. Specify any limitations experienced by the applicant in the following areas:

a) hearing status:

b) vision status:

c) cognitive status:

d) upper mobility status:

e) lower mobility status:

Does the applicant become fatigued easily? Yes No

9. Applicant's ability (select all that apply):

Person is able to press one button to communicate a thought.

Person is able to combine single words to compose a message.

Person is able to use preprogrammed phrases to compose a message.

Person is able to compose a message through spelling.

Person is able to compose a message through typing.

Other (describe):

10. What is the access method needed? (Select one.)

Keyboard Finger Point Head Point Eye Movement

Switch Mouse Joystick

Other (describe access method used):

11. Describe the accuracy of the applicant's access method. Good Fair Poor

12. List any other ACD features not already mentioned that the applicant **requires** in order to use the requested device because of existing disabilities.

Certification

As the certifier, I attest to the following:

- I am eligible to certify under the provisions of STAP.
- The device selected on this form is needed to provide the applicant with access to the telephone network.
- I have personally met with the applicant I am certifying and am aware of the extent of the applicant's disability, which is consistent with the requirements of STAP.
- The applicant's age or disability does not prevent the applicant from using the selected specialized devices to gain access to the telephone network.
- I understand that STAP may request additional documentation as needed to confirm or supplement any information provided on the application, including physician's statements, medical records, or a copy of my license.
- All information I have provided on this application is valid and accurate to the best of my knowledge.

Printed name of certifier:	SLP license number:
----------------------------	---------------------

Name of business:

Street address:	City:	State:	ZIP code:
-----------------	-------	--------	-----------

Telephone:	Fax:	Email:
------------	------	--------

Signature of certifier (must be original, not a photocopy, facsimile, or stamp):	Date:
--	-------