



**TEXAS**

Department of Assistive  
and Rehabilitative Services

**Office for Deaf and Hard of Hearing Services  
Special Needs Funds Request for  
Communication Access Services**

Complete and return this form at least 30 days before the date service is requested. Each request is subject to the approval of the Office for Deaf and Hard of Hearing Services and is evaluated according to priorities set by the agency. Acknowledging DHHS on event materials is required for approval of funds.

**Event Information**

Name of organization requesting funds:	Event name:
Date(s) of event:	Location of event:

**Contact Information**

Name of person requesting funds:	Federal Tax ID Number or State Vendor ID Number:		
Is organization a nonprofit? <input type="checkbox"/> Yes <input type="checkbox"/> No			
Mailing address:	City:	State:	ZIP code:
Phone number:	Alternative number:	Email address:	

**Services Request**

Type of service needed:	<input type="checkbox"/> CART Services		<input type="checkbox"/> Interpreting Services	
	CART Services	Interpreting Services	Total	
Date service is needed				
Number of persons anticipated to use requested services				
Total number of persons anticipated to attend event				
Number of hours service is requested				
Funds requested	\$	\$	\$	

**Event Details**

Describe event and purpose of funds:

  
  
  
  
  
  
  
  
  
  
  

If funds are provided, what are the benefits to the state?

From what other funding sources have funds been requested?

Are services for persons who cannot benefit from assistive listening devices?  Yes  No

Is this an ongoing event?  Yes  No

Intended audience:

Cost per participant to attend the event:

**Applicant Agreement**

I attest that all information is true and understand that

- I must submit an invoice on **organizational letterhead** for services approved under this application, postmarked within 60 days from the last day of the event in order to receive funds; and
- if I do not submit an invoice for funds within 60 days, I will no longer be eligible to receive the funds approved.

Signature:	Date
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**For DHHS Office Use Only**

<input type="checkbox"/> Approved	Amount of funds approved: \$
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<input type="checkbox"/> Not approved	Reason:
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Signature:	Date
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Event number: