WEST VIRGINIA

COMMISSION FOR THE DEAF AND HARD OF HEARING

ACCESSIBLE SMOKE ALARM PROJECT

Application

For office use only:

Date Received: _____________

Date Shipped: ______________

Through a generous grant provided by the West Virginia Division of Rehabilitation Services (DRS), the West Virginia Commission for the Deaf and Hard of Hearing (WVCDHH) is distributing accessible smoke alarms to deaf and hard of hearing individuals that qualify.

To be eligible for this program, you must be a legal resident of West Virginia and own your home. You also may not live in an institution (i.e., dorm, nursing home). Please verify that you meet these requirements on page one of the application.

All information provided is confidential. Please complete the application and return to:

WVCDHH

100 Dee Drive

Charleston, WV 25311

CHECK LIST:

- ☐ Completed *Smoke Alarm Application* (3 pages, including checklist and signed cover page)
- ☐ Completed *Proof of Hearing Loss* form signed by your doctor
- ☐ Copy of most recent audiogram
- ☐ Completed *WV Census of the Deaf and Hard of Hearing* form (optional)

My signature below verifies that all required documents are included with this *Smoke Alarm Application,* and that all information is true and accurate to the best of my knowledge. I understand that I am responsible for the installation of my smoke alarms. I understand that once the smoke alarms are installed, proper maintenance, regular testing and changing the batteries are my responsibility.

Signature	**Printed Name**	**Date**

CONTACT INFORMATION					
Name:					
Address:					
City:	**State:**		**ZIP:**		
County:					
Email:					
Day Phone:	( )	**V**	**TTY**	**VP**	**TEXT**
Eve Phone:	( )	**V**	**TTY**	**VP**	**TEXT**
What is the best way to contact you?	**Email**	**Phone**	**Text**	**Mail**	

ALTERNATE CONTACT PERSON INFORMATION					
Name:					
Email:					
Day	( )	**V**	**TTY**	**VP**	**TEXT**
Eve Phone:	( )	**V**	**TTY**	**VP**	**TEXT**
Relationship to applicant:		**Did this person assist with this application?**			

PROGRAM ELIGIBILITY INFORMATION Please circle your responses		
Are you a legal resident of West Virginia?	Yes	No
Do you own your home?	Yes	No
Are you currently an active client with the Division of Rehabilitation Services (DRS)?	Yes	No
Do you live in an institution (dorm, nursing home, etc.)?	Yes	No

HEARING LOSS INFORMATION

Please circle your responses

Type of hearing loss:

Deaf | Hard of Hearing | Deaf-Blind

Primary Language:

Spoken English | Sign Language | Other:

Will you need printed information in large print or Braille?

No | Large Print | Braille

INFORMATION ABOUT YOUR HOME

How many deaf or hard of hearing individuals live in your home?*	___________
Has anyone else in your home received smoke alarms through this program? Yes If yes, name:	No
What type of home do you live in? (circle one) **Single-family** **Multi-family** **Mobile Home**	
How many floors in your home have a living space? Unfinished basements or an attic that is primarily used for storage or utilities is **not** considered living space.	___________
Approximately how many square feet is your home?	___________
How many bedrooms are in your home?	___________
Where are the bedrooms located in your home? (circle one) **On the same end** **On opposite ends** **On different floors**	
How many bedrooms have deaf or hard of hearing people sleeping in them? (circle one) **If more than one, where are the bedrooms of deaf and hard of hearing people located?** **On the same end** **On opposite ends** **On different floors**	___________

***A separate application must be submitted for each deaf or hard of hearing individual in the home who needs an alarm in their bedroom.**

West Virginia

Commission for the Deaf and Hard of Hearing

Accessible Smoke Alarm Project

Verification of Hearing Loss

Medical Professional:

Your patient is applying to receive an accessible smoke alarm for individuals who are deaf or hard of hearing from the West Virginia Commission for the Deaf and Hard of Hearing. The application requires the following verification that this individual has a hearing loss which warrants a specialized smoke alarm in order to be alerted of fire danger within the home. Please complete this form and return it to the patient for submission with their application.

I, ________________________________, verify that ______________________________________

(Print full name) (Applicant's full name)

has a hearing loss which warrants a specialized smoke alarm in order to be alerted of fire danger within the home.

CONTACT INFORMATION				
Name:				
Please circle one::	**Otolaryngologist/ENT**	**Audiologist**	**Doctor of Medicine**	**Physician's Assistant**
Business Address:				
City:		**State:**	**ZIP:**	
County:				
Email:				
Day Phone:	( )	**V**	**TTY**	**VP** **TEXT**

If you have any questions, please contact:

West Virginia Commission for the Deaf and Hard of Hearing

304-558-1675

Signature	**Printed Name**	**Date**

West Virginia

Commission for the Deaf and Hard of Hearing

Census of the Deaf and Hard of Hearing

WVCDHH is working to maintain a census of information of deaf and hard of hearing individuals in West Virginia. Submission of this information is **optional.** However, Commission staff would like to remind you of the importance of collecting this information. Your **personal** information will kept confidential, and utilized only for urgent and important communications from the Commission. Other general information may be shared with other state agencies upon request in order to facilitate services to deaf, hard of hearing and DeafBlind individuals. This information will allow the Commission to identify the location of deaf and hard of hearing community members, as well as to recognize needs in specific areas. It is important that the Commission have record of this information in order to implement and provide the most necessary services to community members. Thank you for your voluntary participation.

PERSONAL INFORMATION						
Name:			**Date of Birth:**			
Address:						
City:		**State:**	**ZIP:**			
County:						
Email:						
Phone:	( )	**V**	**TTY**	**VP**	**TEXT**	
Eve Phone:	( )	**V**	**TTY**	**VP**	**TEXT**	

HEARING LOSS INFORMATION

Please circle your responses

Degree of Hearing Loss:	**Mild**	**Moderate**	**Moderate/Severe**	**Severe/Profound**	
Type of Hearing Loss:	**Bi-lateral (both ears)**	**Uni-lateral (one ear)**			
Is your loss:	**Sensorineural**	**Conductive**	**Both**		
Age of Hearing Loss:	**Birth**	**Before Language**	**After language**		
Cause of Hearing Loss:	**Hereditary**	**Illness**	**Aging**	**Other: ________________________**	
Communication Mode:	**Sign Language**	**Cued Speech**	**Oral Methods**	**Other: _________________**	
Assistive Devices Used:	**Hearing Aids**	**Cochlear Implant**	**B.A.H.A.**	**F.M. System**	**Closed Captioning**
(circle all that apply)	**TTY/TTD**	**Amplified Telephone**	**Real Time Captioning**	**Other: _______________**	
Highest Education Level:	**Grade _______**	**GED**	**HS Diploma**	**Bachelor's**	**Master's** / **Ph.D**