WEST VIRGINIA

COMMISSION FOR THE DEAF AND HARD OF HEARING

TELEPHONIC COMMUNICATION DEVICE LOAN PROGRAM

Application

For office use only:

Date Received: _____

Date Shipped: _____

The Commission for the Deaf and Hard of Hearing (WVCDHH) is dedicated to ensuring that deaf and hard of hearing West Virginia residents have equal access to communication. Through a federal program, individuals that utilize American Sign Language are able to apply for a video phone free of charge. WVCDHH staff recognizes that a video phone does not meet the needs of all deaf and hard of hearing individuals, and offers alternative equipment through a loan program to meet those needs.

To be eligible for this program, you must be a legal resident of West Virginia and verify that you do not exceed 200% of the poverty rate for household size in annual household income (see page 5).

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

WVCDHH

100 Dee Drive

Charleston, WV 25311

CHECK LIST:

- ☐ Completed *Telephonic Communication Device Loan Program Application* (4 pages, including checklist and signed cover page)
- ☐ Completed *Annual Household Income Information* form
- ☐ Signed and Notarized *Borrower Responsibility Agreement*
- ☐ 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 *TCDLP Application,* and that all information is true and accurate to the best of my knowledge.

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 / REFERENCE **Please provide us with the contact information for a person you have a long standing relationship to. This person must provide a positive reference for you, and will be contacted should we be unable to contact you.**						
Name:						
Address:						
City:	**State:**		**ZIP:**			
County:						
Email:						
Day Phone:	( )	**V**	**TTY**	**VP**	**TEXT**	
Eve Phone:	( )	**V**	**TTY**	**VP**	**TEXT**	
Years Known:	**Relationship to Applicant:**					

PROGRAM ELIGIBILITY INFORMATION **Please circle your responses**		
Are you a legal resident of West Virginia?	Yes	No
Is applicant under the age of 18? *If applicant is under the age of eighteen, a parent/guardian must sign an additional waiver, accepting responsibility for the equipment on the applicant's behalf.	Yes	No
Do you meet the household income requirements? *See page 5 of application	Yes	No

HEARING LOSS INFORMATION

Please circle your responses to allow us to determine what equipment would best suit your needs.

Type of hearing loss:

Deaf Hard of Hearing Deaf-Blind

Primary Language:

Spoken English Sign Language Other:

Type/Model of any assistive listening device you currently use:

Do you use large print or Braille?

No Large Print Braille

Type of Equipment Requested* Please circle your preferred equipment			
Type of Equipment: Amplified Telephone Captioned Telephone TTY			
Do you currently have high speed internet?		Yes	No
If not, are you able to obtain high speed internet?		Yes	No

***Description of Available Equipment for Distribution:**

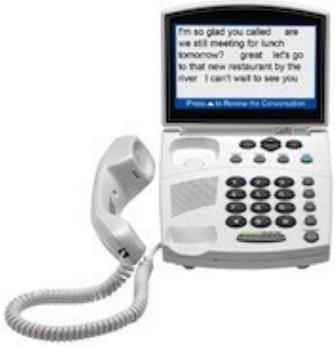
Amplified Telephone —recommended for hard of hearing— Speaker is significantly amplified to assist those with hearing loss. Phones also feature large display and amplified ringer and speaker phone feature.

Currently offering: Fantstel ST-50

Fanstel ST-50

Captioned Telephone —recommended for severely hard of hearing— Individuals are able to speak through the hand set as they normally would. Auditory messages are captioned and displayed on the unit.

Currently offering: CapTel 840 Plus (can be used with standard telephone lines or as an IP-based device)



CapTel 840 Plus

Please note: other models of CapTel captioned phones that require internet access may be available for FREE.
Check online at: http://www.captel.com/freecaptel

TTY (Teletypewriter) — Recommended for deaf/speech impaired— Users type their messages on a keyboard attached to the unit. Auditory messages are received visually through text.

**Please check with WVCDHH to confirm availability of this device as it is limited.

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Annual Household Income Information

Number of people currently living in household: _____

List ALL monthly household income received:

$_____ SSI

$_____ SSD

$_____ Monthly employment earned

$_____ Welfare

$_____ Child Support

$_____ Alimony Payments

$_____ Other - Please identify source(s) and amount of additional income(s) below:

_____

$_____ **Total Monthly Household Income**

Income Limits for Households:

Household Size	200%
1	$30,120
2	$40,880
3	$51,640
4	$62,400
5	$73,160
6	$83,920
7	$94,680
8	$105,440

For families/households with more than 8 persons, add $10,760 for each additional person.

Income limits are 200% of the 2024 federal poverty guidelines,

U.S. Department of Health and Human Services

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Borrower Responsibility Agreement - Affidavit (notarization required)

I, _____

(name of applicant)

of _____

(address of applicant)

in _____ County, West Virginia, being a resident of West Virginia for _____ years.

I understand that the assistive technology that I am borrowing through the Telephonic Communication Device Loan Program is the property of the West Virginia Commission for the Deaf and Hard of Hearing (WVCDHH). I understand that the equipment loaned to me is for my personal use. Equipment may not be sold, donated, disposed of or loaned to another individual. I understand and agree that I am responsible for returning the device to WVCDHH if it is in need of repairs, if I move from the state of West Virginia, if I no longer use the device, or upon my death.

I understand that failure to return borrowed equipment will be considered theft, and I may be held financially liable.

I understand and agree that I am responsible for proper handling and use of the device. I will not remove the stickers indicating that WVCDHH owns the equipment. By agreeing to the terms of this Borrower Responsibility Agreement, I also agree to participate in annual communication with Commission staff to ensure the continued effectiveness of the borrowed equipment.

_____ _____

Signature of Borrower Date

State of West Virginia }
} s.s.
County of _____ }

Taken, subscribed and sworn before me, in said County and State, this _____ day of _____, _____.

_____ Notary Public

My commission expires: _____

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Proof of Hearing Loss – To Be Completed by Medical Professional

Medical Professional:

Your patient is applying to receive a telephonic communication device for individuals who are deaf or hard of hearing from the West Virginia Commission for the Deaf and Hard of Hearing. 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)

is unable to communicate effectively on the telephone without specialized equipment.

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**

Please include copy of applicant's most recent audiogram.

If you have any questions, please contact:

West Virginia Commission for the Deaf and Hard of Hearing

304-558-1675

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

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CENSUS OF THE DEAF AND HARD OF HEARING

OPTIONAL

WVCDHH is working to maintain a census 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**

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Please do not write or mark in the spaces below

____ Loan Approved

____ Loan Denied

If Denied, why? _____

Device Information

Make: _____

Model: _____

Serial Number: _____

Date Loaned: _____

Date Returned: _____

Was device ever replaced or sent for repairs?: ____ Yes ____ No

Condition of returned equipment: ____ Excellent ____ Good ____ Fair ____ Poor ____ Broken

Explain: _____

Name of person checking returned equipment: _____