

**West Virginia Commission for the Deaf and Hard-of-Hearing**  
405 Capitol Street, Suite 800  
Charleston, West Virginia 25301  
(304) 558-1675 or (866) 461-3578

**TELEPHONIC COMMUNICATION DEVICE  
LOAN APPLICATION**

**Personal Information**

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**Name** **Date of Application**

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**Street Address (P.O. Box if applicable)**

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**City** **County** **State** **Zip Code**

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**Phone number** **Email Address**

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**Date of Birth**

Are you a legal resident of West Virginia?  YES  NO

Sex:  Male  Female

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**Contact person (name of nearest relative or friend and phone number)**

**Applicant must be at least 5 years of age to qualify for equipment loans. If the person on this application is between the ages of 5 and 18, then a parent or legal guardian must apply for equipment on their behalf and assume full legal responsibility for equipment.**

## Hearing Information

*Applicant: Please put an "X" on the line beside anything which relates to your own personal hearing loss:*

Deaf: \_\_\_\_\_ Hard of Hearing: \_\_\_\_\_ Deaf/Blind: \_\_\_\_\_

If you are visually impaired, what is your vision loss? \_\_\_\_\_

Do you currently use Braille? \_\_\_\_\_ YES \_\_\_\_\_ NO

*Please complete the Vision Impairment Form if you are applying for a Low-Vision TTY or amplified phone.*

When did your hearing loss begin:

- \_\_\_\_\_ At birth
- \_\_\_\_\_ Pre-lingual (before language is acquired)
- \_\_\_\_\_ Post-lingual (after language is acquired)

What is your degree of hearing loss:

- \_\_\_\_\_ Mild - 25 to 40 db loss
- \_\_\_\_\_ Moderate – 41 to 55 db loss
- \_\_\_\_\_ Moderate Severe – 56 to 70 db loss
- \_\_\_\_\_ Profound – 91 db loss or greater
- \_\_\_\_\_ A Fluctuation Hearing Loss

**PLEASE INCLUDE COPY OF MOST RECENT AUDIOLOGICAL EXAM  
(HEARING TEST) WITH LOAN APPLICATION**

Are you speech-impaired? \_\_\_\_\_ YES \_\_\_\_\_ NO  
(You are able to hear but unable to use your voice to communicate)

Do you have any disability other than deafness? \_\_\_\_\_ YES \_\_\_\_\_ NO

If you answered "YES" to the above question, please explain:

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What is the cause of your hearing loss:

- |  |  |
|--|--|
| <input type="checkbox"/> Unknown                             | <input type="checkbox"/> Rh Incompatibility Factor |
| <input type="checkbox"/> Heredity                            | <input type="checkbox"/> Noise exposure            |
| <input type="checkbox"/> Rubella (from 1963-1965)            | <input type="checkbox"/> Otosclerosis              |
| <input type="checkbox"/> Drugs toxic to your auditory system | <input type="checkbox"/> Infection                 |
| <input type="checkbox"/> High fever                          | <input type="checkbox"/> Waardensburg Syndrome     |
| <input type="checkbox"/> Aging                               | <input type="checkbox"/> Respiratory Distress      |
| <input type="checkbox"/> Birth trauma                        | <input type="checkbox"/> Fetal Alcohol Syndrome    |
| <input type="checkbox"/> Head trauma or injury               | <input type="checkbox"/> Usher's Syndrome          |
| <input type="checkbox"/> Premature birth                     | <input type="checkbox"/> OTHER:                    |

Do you currently use a hearing aid?  YES  NO  
If you answered YES, what is the make and model? \_\_\_\_\_

Do you currently use a cochlear implant?  YES  NO

**PLEASE PUT AN "X" BESIDE THE TYPE OF EQUIPMENT FOR WHICH YOU ARE APPLYING:**

- Amplified Phone—adjustable volume and clarity for the hard of hearing
- TTY—device for the deaf that requires writing and typing to communicate with those who have a TTY or by using the WV Relay system
- Low-Vision Amplified Phone—Amplified phone with large numbers for easier dialing
- Low-Vision TTY—TTY with large display for the vision impaired

Are there other family members who will be using this equipment?  YES  NO  
If so, please complete the following:

Name of person: \_\_\_\_\_

Relationship to you: \_\_\_\_\_ Age: \_\_\_\_\_

\*\*\*\*For multiple family members, please list below\*\*\*\*

**Income Information**

Number of people currently living in household: \_\_\_\_\_

List of 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

**Current Income Limits for Households:**

One person	\$ 18,366	Five persons	\$ 43,488
Two persons	\$ 23,512	Six persons	\$ 49,152
Three persons	\$ 28,696	Seven persons	\$ 56,002
Four persons	\$ 36,784	Eight persons	\$ 61,814

**\*\*Income limits are 200% of the 2002 poverty rate, U.S. Census Bureau**

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**Please do not write or mark in the spaces below**

TTY/TDD Information: \_\_\_\_\_  Loan Approved  
\_\_\_\_\_  Loan Rejected  
Make: \_\_\_\_\_ If loan was rejected,  
Model: \_\_\_\_\_ state reason: \_\_\_\_\_  
Serial Number: \_\_\_\_\_  
Date loaned: \_\_\_\_\_  
Date returned: \_\_\_\_\_

Name of person checking returned equipment: \_\_\_\_\_

Condition of equipment when returned:

Excellent  Good  Fair  Poor  Broken

Explain:

Was TTY/TDD ever replaced or sent for repairs  YES  NO

Explain:

# Telephonic Communication Device

304-558-1675 - Toll Free 866-461-3578

## LOAN AFFIDAVIT

I, \_\_\_\_\_  
(name of applicant)

of \_\_\_\_\_  
(address of applicant)

in \_\_\_\_\_ County, West Virginia, being a resident of West Virginia for \_\_\_\_\_ years. I do solemnly swear that the information given on the application for the WV Commission for the Deaf and Hard-of-Hearing Telephonic Communication Device Loan Program is true to the best of my knowledge. I promise to take care of the equipment and to return it to the above agency if it is in need of repairs, if I move from the state of West Virginia, or upon my death.

Signature \_\_\_\_\_

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: \_\_\_\_\_

**West Virginia Commission for the Deaf and Hard-of-Hearing  
405 Capitol Street, Suite 800  
Charleston, WV 25301**

**This page may be omitted with a copy of a valid West Virginia driver's license with a clearly visible deaf or hard-of-hearing designation. A copy of the audiogram or hearing test may also be omitted if the driver's license is provided.**

**I hereby certify that this loan applicant is unable to communicate effectively on the telephone without specialized equipment or the use of a Telecommunication Device for the Deaf (TTY). Persons qualified to certify the eligibility of the applicant include (Please put an "X" beside the one which best describes you):**

- Otolaryngologist (Ear, Nose & Throat Specialist)**
- Audiologist**
- Doctor of Medicine**
- Registered Nurse**
- Other (Must be a medical professional)**

**Name of person applying for TTY/equipment loan**

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**Your Name (Please print or type)**

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**Your signature**

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**Business Address**

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**City**

**State**

**Zip Code**

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**Phone Number**

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**Date**

**Month/Day/Year**

**Please attach a copy of the most recent hearing test. If a hearing test is not applicable, for example deaf since birth or early age, please explain:**