

West Virginia Commission for the Deaf and Hard-of-Hearing
Capitol Complex Building 6 Room 863
Charleston, West Virginia 25305
(304) 558-1675 or (866) 461-3578 (v/tty)

**TELEPHONIC COMMUNICATION DEVICE
LOAN APPLICATION**

Personal Information

Name **Date of Application**

Street Address (P.O. Box if applicable)

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

Phone number **Email Address**

Social Security Number **Date of Birth**

Are you a legal resident of West Virginia? **YES** **NO**

Sex: **Male** **Female**

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:

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	\$ 20,588	Five persons	\$ 48,764
Two persons	\$ 26,334	Six persons	\$ 55,120
Three persons	\$ 32,158	Seven persons	\$ 64,410
Four persons	\$ 41,288	Eight persons	\$ 69,548

****Income limits are 200% of the 2006 poverty rate, U.S. Census Bureau**

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 voice/tty - Toll Free 866-461-3578 (V/TTY)

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: _____

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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

Your Name (Please print or type)

Your signature

Business Address

City

State

Zip Code

Phone Number

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: