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

Name **Date of Application**

Street Address (P.O. Box if applicable)

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

Phone number **Email Address**

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:

_____Unknown
_____Heredity
_____Rubella (from 1963-1965)
_____Drugs toxic to your auditory system
_____High fever
_____Aging
_____Birth trauma
_____Head trauma or injury
_____Premature birth
_____Rh Incompatibility Factor
_____Noise exposure
_____Otoscierosis
_____Infection
_____Waardensburg Syndrome
_____Respiratory Distress
_____Fetal Alcohol Syndrome
_____Usher's Syndrome
_____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**
****

Please do not write or mark in the spaces below

TTY/TDD Information:

Make: _____
Model: _____
Serial Number: _____
Date loaned: _____
Date returned: _____

_____Loan Approved
_____Loan Rejected
If loan was rejected, state reason: _____
_____
_____
_____

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

_____

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: