State of Rhode Island and Providence Plantations
Department of Human Services
Office of Rehabilitation Services

Adaptive Telephone Equipment Loan (ATEL)Program

40 Fountain Street ~ Providence, RI 02903
401-421-7005 ext. 357 ~ 401-222-3574 FAX ~ TTY (401) 222-1679

APPLICATION FORM

Name_____
(First) (Middle Initial) (Last)
Address_____
(Street) (Apt #)
_____RI_____
(City) (State) (Zip Code)
Telephone # (401)_____ (*You must have an active home number.*)

Cell phone # (401) _____Date of Birth ____/_____/_____

Who should we contact to set up an appointment?
(Please check one of the following):
___Myself at the number listed above
___Alternate below Relationship_____
Name_____ Daytime telephone _____

***HOW WOULD YOU LIKE TO RECEIVE YOUR EQUIPMENT?

(Please check one of the 3 choices):

As soon as possible, myself or a family/friend is available to pick-up the equipment, when notified by the ATEL office that the equipment is available.
1.___Department of Human Services, 40 Fountain St, Providence(8:30-4, M-F)
2.___TechACCESS,110 Jefferson Blvd, Warwick (8:30-4, M-F)
-Or-
3.___ I do not have anyone available to pick-up the phone, and would like to wait approximately 3-4 weeks for a home visit; depending on length of waiting list and equipment availability. Appointments are scheduled (between 9-4, in a 2-3 hour time slot, Tues.-Thurs).

Do not write in this box. For office use only.
Case Number_____ Date Received_____

PLEASE COMPLETE ALL 3 PAGES OF APPLICATION

PLEASE FILL OUT TO THE BEST OF YOUR ABILITY

1. Do you have any of the following disabilities?: (Please Check One):
   __ Deaf ___ Deaf-Blind ___ Speech Disability ___ Non-Verbal
   ___ Hard of Hearing ___ Hard of Hearing and Sight Disability
   ___ Neuromuscular Damage or Disease _____.
   (Specify disability)
2. Have you or anyone in your household been issued equipment from the ATEL program? ___ yes ___ no

3. Who is your telephone service provider? _____

4. Which features does your telephone plan include:
   ___ Caller ID ___ Voice mail ___ other_____

5. Do you have the internet? ___ no ___ yes, email address:
   _____

6. ATEL can only issue one device per household, so please check the options that are **MOST** important to you:

   ___ Simple and easy to use ___ Cordless

   ___ Captions (corded only) ___ Other_____

   ___ Emergency Feature (I live alone and I am worried about falling).

7. Would you like us to mail an application to a family member or friend that could benefit from the ATEL Program? ___ yes ___ no
   If yes, what is their name and mailing address?

_____
_____
_____
_____

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I certify that I meet either of the following income qualifiers for eligibility in the program (please check below); if you do not qualify, please call our office and we can refer you to the appropriate vendor:

___ I receive one or more of the following: food stamps, Medicaid, SSI, heating assistance, rite care, family independence program, general public assistance, RIPAE (assisting tiers 60% and 30%) or telephone lifeline service.

-Or-

___ Our household combined annual income is below the 250% poverty line.

Size of Family	**Eligibility Guidelines/ 250% poverty level**		
1	**$28,725**	**$2,394**	**per month**
2	**$38,775**	**$3,231**	**per month**
3	**$48,825**	**$4,069**	**per month**
4	**$58,875**	**$4,906**	**per month**
5	**$68,925**	**$5,744**	**per month**

***You will need to have a copy of a paycheck, pension check, or documentation of eligibility for any of the programs noted above at the time of your appointment.**

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I understand that this information will be kept confidential and will only be used as required for assistance, reports and audits. My signature below authorizes the ATEL program to contact my telephone carrier to verify service. I hereby certify that all statements made by me in this application form are true and correct to the best of my knowledge and belief. As long as I am receiving services, I agree to notify the agency if there is any change of the information furnished on this form.

_____ _____

Signature of applicant Date

_____

Printed name, and if not applicant, relationship to applicant

(Parent or guardian should sign if under 18 years of age)

PLEASE MAIL YOUR APPLICATION AND SIGNED CERTIFICATE OF DISABILITY TO:

Department of Human Services
Office of Rehabilitation Services
ATEL Program, 5TH Floor
40 Fountain Street,
Providence, RI 02903