NEW CLIENT APPLICATION

(Renewal Clients, Call ITAC)

Illinois Telecommunications Access Corporation
800-841-6167 V/TTY
www.itactty.org

A FREE program REQUIRED by Illinois Law

BASIC REQUIREMENTS:

- Resident of Illinois
- Active phone service
- Application signed by Doctor/Professional (page 2)

You Need To Do These Four Things:

1. **Complete Application:**
   Client completes page 1.
   Have Page 2 completed and signed by your Doctor/Certifier.
2. **A Copy of your recent Phone Bill/s:**
   Both Landline *and* Cellular if you are applying for both types of equipment.
   (The pages that show your name, address, phone number, all taxes & other fees)
   Applicants with *prepaid cell phones* **must** bring phone when testing equipment.
3. **Proof of Residency:**
   Copy of your Driver's License, State ID, or piece of mail.
   (showing same address as on the application)
4. **Send this Original, Completed Application to:** ***ITAC***
   3001 Montvale Drive, Ste A, Springfield, IL 62704

***NOTE: Include Pre-Selection Form if you have already tested the phones.**

Full Name (Mr., Mrs., Ms.) (Please print)		Date of Birth (Month/Day/Year)
Last 4 Numbers of Social Security Number (Required) XXX-XX-	Landline Area Code & Phone Number	Cellular Area Code & Phone Number
Street Address	Apt. #	City, State, Zip Code
E-Mail Address of Applicant or Contact Person	Name of Landline Telephone Company	Name of Cellular Company

Disability:
- ☐ Deaf
- ☐ Hard of Hearing
- ☐ Late-Deafened
- ☐ Speech Disabled
- ☐ Deaf-Blind

Equipment Applied For:
- ☐ Cell Phone Amplifier
- ☐ Amplified Phone
- ☐ Captioned Phone
- ☐ TTY

Method of Communication:
- ☐ Sign Language
- ☐ Lip Reading
- ☐ Spanish Available at Some Locations
- ☐ Normal Speech Skills

- You will try the Equipment to determine which best meets your needs.
- Have you already tested the phones?_____ Where?_____
- Do you or a member of your household currently have a phone from ITAC?_____

SIGNATURE OF APPLICANT _____ **Date** _____
If under 18, Parent Signature Required

All Information Provided is STRICTLY CONFIDENTIAL

VOUCHER SENT _____

Have your Doctor/Professional Fill in and Sign this side

Applicant must be deaf, hard of hearing, speech disabled or deaf-blind to the extent that they are unable to use a standard phone.

People Who Can Sign the Application Are:

- Your Doctor/Nurse Practitioner
- Audiologist
- Licensed Hearing-Aid Dispenser
- DHS Counselors for the Deaf
- Speech-Language Pathologist

Disability Being Certified:

- ☐ Deaf
- ☐ Hard of Hearing
- ☐ Late-Deafened
- ☐ Speech Disabled
- ☐ Deaf-Blind

* Does applicant read Braille?
☐ Yes ☐ No At what level? _____

State of Disability Is:

- ☐ Temporary
- ☐ Intermittent
- ☐ Permanent

*Disablility must be permanent, but may be intermittent.

Equipment choice is not binding. Final choice will be determined by client's testing of equipment.

The goal of this program is to match the client with the piece of equipment that works best for them.

Equipment Applied For:

☐ **Cell Phone Amplifier**
Serves people who are Hard of Hearing with cellular phone service.

☐ **Amplified Phone**
Choice of amplified phones to meet various levels of hearing loss.

☐ **Captioned Phone**
Serves people who are Deaf or Late Deafened who MUST have excellent speech skills. Calls are made using a captioning relay service.

☐ **TTY**
Serves people who are Deaf and/or Speech Disabled. Calls can be made from TTY to TTY or by using a relay service.

☐ **Deaf-Blind Equipment**
*Evaluator will meet with client to determine eligibility.

Name of Physician/Provider	
Title	State License Number
Address	
City, State, Zip	Area Code & Telephone Number
Name of Applicant	Last 4 Numbers of Applicant's Social Security Number

I affirm that the person named on this application meets the certification requirements of being Deaf, hard-of-hearing, speech disabled or deaf-blind as stated above to the extent that they are unable to use the standard telephone.

Signature: _____ **Date** _____