

Michigan Association for Deaf and Hard of Hearing (MADHH) Statewide Program for TTY or Other Assistive Equipment Instructions

Purpose

The purpose of this program is to provide Assistive Equipment to those who are on public assistance or whose income is below the Federal Poverty Guidelines for their family size. At this time there is no money for this program. MADHH is working with civic organizations such as the Lions of Michigan and other funding sources in trying to obtain money for this program.

General Instructions

- M Read instructions before filling out forms.
- M Print all information requested.
- M Use a pen.
- M **If you have any questions about filling out these forms, please call MADHH.**

If you are calling within the Lansing area, call (517) 487-0066 (V) or (517) 487-0202 (Assistive Equipment). If you are not calling from the Lansing area, call toll-free 1-800-YOUR-EAR (Assistive Equipment).

To apply for a **Assistive Equipment** under the MADHH Statewide Assistive Equipment Program, you must fill out the following forms:

Application Form—Part 1

If the person receiving the Assistive Equipment is under 18 years of age, the parent or guardian must also sign the form at the bottom next to where it says "Parent/Guardian Signature".

Certification of Impairment—Part 2

You must give this form to a Doctor, Audiologist, Hearing Aid Dispenser, Speech/Language Pathologist or Rehabilitation Counselor/Assistant to fill out.

Public Assistance Verification Form—Part 3

If you are receiving Public Assistance, fill out the top part of this form including your signature and date. MADHS will send the form to the Department of Human Services to fill in the bottom part of the form.

Send the completed forms to:

**MADHH
Assistive Equipment Program
2929 Covington Court, Suite 200
Lansing, MI 48912-4939**

**517/487-0066 V/TTY
800/YOUR EAR
517/487-2568 FAX
sadonna@madhs.org E-Mail**

MADHH Statewide TTY or Other Assistive Equipment Program Application Form—Part 1

Please read the instructions before filling out this form. You must be a resident of Michigan to fill out this form and obtain Assistive Equipment under this program.

Last Name	First Name	Middle Initial	Birth Date
Street	Apt./Box Number		City
	()		State
Zip	Phone Number	E-Mail Address	

1. Do you presently own a telephone? Yes No
If yes, list phone number where you can be contacted: _____

2. Are you a student: _____ Yes No
If yes, please list: Age: _____ Grade In School: _____

3. Please check all boxes which apply to you:

A. Receive Aid to Family Independence Program (FIP).

B. Receive Food Assistants Program (FAP).

C. Receive Medicaid (MA).

D. Receive Social Supplemental Income (SSI).

E. My family income is below Federal Poverty Guidelines for my family size, as shown in the table below. **If you checked this box, you must also attach a copy of your Federal Income Tax Return—Form 1040.**

Federal Poverty Level Guideline Table - Family Size

# in Family (Circle One)	1	2	3	4	5	6	7	8	
Year	2005	\$ 9,570	\$12,830	\$16,090	\$19,350	\$22,610	\$25,870	\$29,130	\$32,390
	2006	\$ 9,800	\$13,200	\$16,000	\$20,000	\$23,400	\$26,800	\$30,200	\$33,600

(For families of more than 8 members, add an each additional \$3,400 per person)

I am requesting the following: _____
through the assistance of the Michigan Association for Deaf and Hard of Hearing. I certify that I am deaf, hearing impaired or speech impaired. I certify that the information provided on this form is true and accurate to the best of my knowledge.

Signature: _____ Date: _____

Parent/Guardian Signature: _____ Date: _____

MADHH Statewide TTY or Other Assistive Equipment Program Certification of Impairment—Part 2

Take this form to your Doctor, Audiologist, Hearing Aid Dispenser, Speech/Language Pathologist, or Rehabilitation Counselor/Specialist to be filled out.

Name of Applicant: _____

City	State	Zip	County
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Please check the appropriate box. Use the definitions next to the boxes to determine the appropriate box to check.

- Deaf/Severely Hearing Impaired:** A hearing loss that requires use of Assistive Equipment.
- Severely Speech Impaired:** A speech impediment that renders speech on an ordinary telephone unintelligible.
- Deaf-Blind:** A hearing loss and a visual impairment that require use of Assistive Equipment to communicate effectively.
- Doctor:** Any person eligible to practice medicine in the State of Michigan.
- Audiologist:** A person who has a Masters or Doctoral degree in audiology and a Certificate of Clinical Competence in audiology from the American Speech/Language/Hearing Association.
- Hearing Aid Dispenser:** A person who is licensed by the Michigan Department of Public Health to fit and dispense hearing aids and who is certified in Hearing Instrument Sciences by the National Board for Certification in Hearing Instrument Sciences.
- Speech/Language Pathologist:** A person who has a Masters Degree or equivalence in Speech/Language Pathology and a Certificate of Clinical Competence issued by the American Speech/Language/Hearing Association.
- Rehabilitation Counselor/Specialist:** A person employed in an agency providing services to the hearing-impaired population.

Signature of Certifying Agent	Agency/Organization
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Name (Please Print) _____

Address	City	State
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Phone	Date
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**MADHH Statewide TTY or Other Assistive Equipment Program
Public Assistance Verification Form—Part 3**

Complete the **top** portion of this form if you are certifying that you are a public assistance recipient (FIP, SSI, MA, or FIP). *If you fail to complete this form, we will be unable to determine your eligibility for a Telecommunication Device for the Deaf (TTY/TDD).*

Name

Street

City

State

Zip

Case Number or Social Security Number

I authorize the Michigan Department of Human Services, Family Independence Agency to release necessary information to Michigan Association for Deaf and Hard of Hearing to certify my eligibility for a Telecommunication Device for the Deaf (TTY/TDD).

Signature

Date

(For FIA Office Use Only)

**Michigan Department of Human Services
Family Independence Agency Verification**

I certify that the above is a public assistance recipient of the Michigan Department of Human Services, Family Independence Agency.

Name: _____

Title: _____

Signature: _____ **Date:** _____