

# Application for the Nebraska Equipment Distribution Program

**A.**

*(Please Print)*

NAME: \_\_\_\_\_  
*(Last) (First) (Middle Initial)*

HOME ADDRESS: \_\_\_\_\_  
*(Number and Street Name, or PO Box) (Apt #)*

CITY: \_\_\_\_\_ STATE: \_\_\_\_\_ ZIP: \_\_\_\_\_ COUNTY: \_\_\_\_\_

DAYTIME PHONE: ( ) \_\_\_\_\_ V/TTY/Both HOME PHONE: ( ) \_\_\_\_\_ V/TTY/Both  
*(Circle One) (Circle One)*

SOCIAL SECURITY NUMBER: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ BIRTH DATE: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_  
*(Mo) (Day) (Yr.)*

*Name of someone who can help us contact you: (a person not living with you)*

NAME: \_\_\_\_\_ TELEPHONE: ( ) \_\_\_\_\_ V/TTY/Both  
*(Circle One)*

ADDRESS: \_\_\_\_\_ CITY: \_\_\_\_\_ STATE: \_\_\_\_\_ ZIP: \_\_\_\_\_

**B.**

## EQUIPMENT NEEDS

### Part 1 – Telephone Equipment - (Please Check Only One)

- Computer Conversion Package (TTY modem only)
- Phone with Amplification (Built-in)
- Phone Amplifier
- TTY/TT (with 6 rolls of paper maximum)
- Voice Carry Over (VCO) Phone
- Other (please specify) \_\_\_\_\_

#### Additional application required:

- Large Visual Display
- Tactile Ring Signaler
- Telebrailer

### Part 2 – Phone Signaling Devices – (Please Check Only One)

- Light Signaler Phone Ring - Master  
\_\_\_\_\_ Number of remote receivers needed (Limit of 2)
- Phone Ringer
- Personal Vibrator
- Other (What Kind – example, “Alertmaster”) \_\_\_\_\_

**C.**

## ELIGIBILITY

- | Yes                      | No                       |   |
|--------------------------|--------------------------|---|
| <input type="checkbox"/> | <input type="checkbox"/> | I have a hearing, visual and hearing loss, or speech disability which prevents me from using the telephone effectively. |
| <input type="checkbox"/> | <input type="checkbox"/> | I am three years of age or older, and can demonstrate the ability to use the equipment.                                 |
| <input type="checkbox"/> | <input type="checkbox"/> | I now have phone service or have applied for phone service in the state of Nebraska at my place of residence.           |
| <input type="checkbox"/> | <input type="checkbox"/> | I am a current resident of the state of Nebraska.   |
| <input type="checkbox"/> | <input type="checkbox"/> | Have you ever applied for this program? If yes, approximate month and year ____/____                                    |

**The above facts are true and complete to the best of my knowledge.**

**X** \_\_\_\_\_ DATE \_\_\_\_\_  
*(Applicant or Guardian's Signature if applicant is under 18 years of age)*

# PROFESSIONAL CERTIFICATION

(to be completed by certifier)

I certify this applicant as one of the following:

- Deaf       Hard of Hearing       Speech Disability       Deaf-Blind

(check one of the following and provide appropriate information)

- Assistive Technology Project Representative (ATP)  
 Audiologist or Licensed Hearing Aid Dispenser  
 Augmentative Speech Pathologist  
 Center for Independent Living Representative  
 Licensed Physician/Assistant  
 Nebraska Commission for the Deaf and Hard of Hearing (NCDHH)  
 Services for the Visually Impaired Representative (SVI)  
 Speech Pathologist  
 Vocational Rehabilitation Representative (VR)  
 Other \_\_\_\_\_

This individual requires other adaptive equipment (specify): \_\_\_\_\_

(Please Print)

NAME: \_\_\_\_\_

AGENCY NAME: \_\_\_\_\_

ADDRESS: \_\_\_\_\_

CITY: \_\_\_\_\_ STATE: \_\_\_\_\_ ZIP: \_\_\_\_\_

TELEPHONE: (     ) \_\_\_\_\_ FAX: (     ) \_\_\_\_\_

E-MAIL ADDRESS: \_\_\_\_\_

X \_\_\_\_\_ DATE: \_\_\_\_\_  
(Certifier's Signature) (Title)

## INTERNAL USE ONLY

Approved

Denied

COMPLETED BY: (Please Print)

NAME: \_\_\_\_\_ AGENCY: \_\_\_\_\_

ADDRESS: \_\_\_\_\_

CITY: \_\_\_\_\_ STATE: \_\_\_\_\_ ZIP: \_\_\_\_\_

PHONE NUMBER: (     ) \_\_\_\_\_

E-MAIL ADDRESS: \_\_\_\_\_

X \_\_\_\_\_ DATE: \_\_\_\_\_  
(NEDP Coordinator's Signature)

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