NEW CLIENT APPLICATION
(Renewal Clients, Call ITAC)

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

A FREE program REQUIRED and GOVERNED by Illinois Law

BASIC REQUIREMENTS:

- Legal Resident of Illinois
- **Standard Phone Service**, most **Cable** or **VoIP**, in your residence. (Call or check **www.itactty.org** for participating companies.) **Cellular companies are NOT eligible!**
- Application signed by Doctor or approved certifier that Applicant is deaf, hard of hearing, speech disabled or deaf/blind and **unable to use a standard phone**.

You Need To Do These Four Things:

1. **Complete Page 1.** Have Page 2 completed and signed by your Doctor, Audiologist or DHS Counselor
2. **Send this Original, Completed Application (no faxed copies)** to: ITAC, 3001 Montvale Drive, Suite D, Springfield, IL 62704
3. **Include** a Copy of Your **Most Recent Phone Bill** (The pages that show your name, address, phone number, all taxes & other fees)
4. **Include Proof of Residency**: Copy of a Driver's License, State ID or Piece of Mail Showing the Same Address as on the Application

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

Full Name (Mr., Mrs., Ms.) (Please print)		Area Code & Phone Number
Social Security Number (Required)	Date of Birth (Month/Day/Year)	
Street Address	Apt. #	City, State, Zip Code
E-Mail Address of Applicant (if available)	Name of Local Telephone Company	

Disability:

- ☐ Deaf
- ☐ Late Deafened
- ☐ Hard of Hearing
- ☐ Speech Disabled
- ☐ Deaf/Blind
- ☐ Deaf, Hard of Hearing or Speech Disabled with Low Vision

Method of Communication:

- ☐ Sign Language ☐ Normal Speech Skills
- ☐ Lip Reading
- ☐ Spanish (available in Chicago only)

Equipment Applied For: 1 Unit Only (See Page 2 for Equipment Descriptions)

- ☐ Amplified Telephone (Voucher Program)
- ☐ TTY (Voucher Program)
- ☐ Captioned Telephone (Loan Program)
- ☐ Braille Phone (Loan Program)
- ☐ TTY with Large Visual Display (Loan Program)

- **You will test this 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? _____

(One phone per household every four years.)

SIGNATURE OF APPLICANT _____ **Date** _____

PARENT OR LEGAL GUARDIAN IF APPLICANT IS UNDER AGE 18:

Name:	Social Security Number:		Area Code & Phone Number
Street Address	Apt. #	City, State, Zip Code	
E-Mail Address:	**Signature of parent of legal guardian** (If applicant is under age 18)		**Date:**

All Information Provided is STRICTLY CONFIDENTIAL

VOUCHER SENT _____

Have Your Doctor or Audiologist 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
- Your Audiologist
- DHS Counselors for the Deaf

Note: ***Hearing Aid Dispensers*** **CANNOT** ***sign*** **unless they are licensed audiologists.**

Disability Being Certified:

☐ Deaf
☐ Hard of Hearing
☐ Speech Disabled
☐ Late Deafened
☐ Speech Disabled, Low Vision
☐ Speech Disabled, Blind*
☐ Deaf, Blind*
☐ Deaf, Low Vision

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

State of Disability Is:

☐ Temporary
☐ Intermittent
☐ Permanent

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

The goal of this program is to issue you the piece of equipment that works best for you.

Equipment Applied For: 1 Unit Only

☐ **TTY (Voucher Program)**
Serves people who are Deaf and Speech Disabled. Calls can be typed from TTY to TTY and to or from a standard phone using a relay service. Choice of three (3) print sizes meets most low vision needs.

☐ **Amplified Telephones (Voucher Program)**
The amplified telephones serve people with moderate to severe hearing loss using the standard phone system.

☐ **CapTel Phone – Captioned Telephone (Loan Program)**
Serves people who are Deaf and Late Deafened who MUST have excellent speech skills. Calls are made using a captioning **relay service**.

☐ **Braille Phone (Loan Program)**
Serves people who are Deaf Blind and/or Speech Disabled Blind. MUST read Braille.

☐ **TTY with Large Visual Display (Loan Program)**
Serves people who are Deaf with low vision or speech disabled with low vision. Calls can be made and received in same manner as a TTY. The LVD unit is a separate display that attaches to an adapted TTY.

Name of Physician, Audiologist or DHS Counselor (Please Print)	
Title	State License Number
Address	
City, State, Zip	Area Code & Telephone Number
Name of Applicant	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** _____

For ITAC office use only: Approved _____ **Date**_____