



Phone: 800.841.6167 v/tty

Illinois Telecommunications Access Corporation

**IMPORTANT – Read, Sign and Return top copy  
with your application – LOAN PROGRAM ONLY**

***Responsibilities and Obligations of the person loaned equipment by ITAC***

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As a **recipient** of ITAC equipment, you have the following **legal responsibilities and obligations** as set forth by Illinois law (83 IL Administrative Code, Part 755): (*The words “approved recipient” and “you” mean the parent or legal guardian in cases where the applicant is a minor.*)

- 1. All equipment in the loan program belongs to ITAC and will remain property of ITAC.**
- 2. The equipment loaned by ITAC must never be sold or loaned to anyone, or transferred out of your possession.** Selling, loaning, or transferring the equipment makes you liable for the total replacement cost.
- 3. If the equipment needs repaired, do not attempt to repair it yourself.** (If you do, you will be liable for all costs to repair or replace the equipment.) Call ITAC or an ITAC Selection Center to exchange your equipment.
- 4. If you are without telephone service for at least 45 days** (due to disconnection because you have moved or not paid your telephone bill) **all equipment must be returned to ITAC.** If your telephone service is reconnected, you should call ITAC for reinstatement to the program.
- 5. You must immediately report any change in your address or telephone number to ITAC.**
- 6. You are not allowed to take ITAC equipment out of the state of Illinois.** If you move out of Illinois, all of the equipment loaned by ITAC must be returned **before** you leave the state. Removal of ITAC equipment from Illinois will subject you to liability for the full replacement cost.
- 7. If your equipment is lost, stolen or damaged, contact ITAC immediately. If stolen, you must provide ITAC with the police report number within 5 working days.**
- 8. ITAC will assume all reasonable expenses to maintain and repair your equipment. If equipment is damaged, lost, or destroyed because of negligence or abuse, you must pay for replacing or repairing the equipment.** ITAC will only pay for damage caused by normal wear and tear on equipment.
- 9. In the event of the death of the approved recipient, the executor or other responsible person must return the equipment to ITAC or an ITAC Selection Center within thirty (30) days.**
- 10. If the approved recipient moves out of state or dies, and another eligible person living in the same residence wishes to keep the equipment, that person must file a new application form with ITAC within ten (10) days** in order to keep the equipment.
- 11. In cases where the approved recipient is a minor, all ITAC equipment and obligations and responsibilities set forth by this document will be transferred to the recipient on the recipient’s eighteenth (18<sup>th</sup>) birthday.**

**Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_  
(Applicant or Legal Guardian)

*For Your Information: The names and addresses of the ITAP Advisory Council, comprised of seven members who are representatives of people with disabilities, will be made available to you if you have a comment or complaint. This information can be given to you at any ITAC Selection Center. The Illinois Commerce Commission’s Staff Liaison, who serves as a contact person, advisor and monitor of the Advisory Council, can be reached at 1.800.858.9277 TTY or 1.800.524-0795 V.*

**ITAC COPY**

1/2007



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**www.itactty.org**

# APPLICATION

A FREE program REQUIRED and GOVERNED by Illinois Law

## BASIC REQUIREMENTS:

- Legal Resident of Illinois
- Standard Phone Service in Your Residence  
(Cellular, Internet Based, Wireless, VOIP, and Cable Services 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 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

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

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

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

### Method of Communication:

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

- **You will test this Equipment to determine which best meets your needs.**
- Have you previously applied to the ITAC Equipment Program?    Yes \_\_\_ No \_\_\_

**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:	<b>Signature of parent of legal guardian</b> (If applicant is under age 18)	<b>Date:</b>

## 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.**

**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.**

**People Who Can Sign the Application Are:**

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

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

**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 Telephone (Voucher Program)**

The amplified telephone serves 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.

**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

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 \_\_\_\_\_**