Application

Administered by the South Carolina School for the Deaf and the Blind

Applicant Information

Please print clearly in blue or black ink.

First Name:________________________________ MI:_________ Last:____________________________________

Home Phone: _____-_____-______TTY / voice (circle one) Other Phone _____-_____-______TTY / voice (circle one)

Address:____________________________ City:________________ County:________ State:_____ Zip:__________

Birth Date: ___ /___ /_____ Social Security (last four): ______ Email Address:_________________________

Contact Person____________________________ Phone: _____-_____-______ Other Phone: _____-_____-______

How did you learn about SCEDP?____

Guardian Information

First Name:________________________________ MI:_________ Last:____________________________________

Home Phone: _____-_____-_____TTY / voice (circle one) Other Phone: _____-_____-_____TTY / voice (circle one)

Address:______________________________ City:_____________ County:________ State:_____ Zip:__________

Product Selection

Choose only one telecommunications product and one alerting device or accessory.

To learn about which product is right for you, please refer to the SCEDP Product Guide or visit www.scedp.org

Telecommunications Products

- ❑ 1. Amplified Phone
- ❑ 2. CapTel Phone
- ❑ 3. Uniphone
- ❑ 4. TTY Superprint
- ❑ 5. Amplified Handset
- ❑ 6. Photo Phone
- ❑ 7. Large Number Phone
- ❑ 8. TTY Superprint Pro80
- ❑ 9. Electro Larynx
- ❑ 10. Hands-Free Phone
- ❑ 11. M3/Dynavox
- ❑ 12. PhoneIT
- ❑ 13. FSTTY PACmate

Alerting Devices and Accessories

- ❑ A. AM-100
- ❑ B. AM-6000
- ❑ C. Tactile Signaler
- ❑ D. Telephone Ear Pad

For Hands-Free Phone only

- ❑ Headset/Microphone
- ❑ Air Switch
- ❑ Pillow Switch

Provide Document Copies

Either applicant or guardian documents are accepted. COPIES ONLY

- ❑ Copy of your valid South Carolina identification. (SC driver's license, SC ID card, or SC voter registration)
- ❑ Copy of a page from your current phone bill showing your phone number and address.
- ❑ Guardian: For M3/Dynavox or FSTTY PACmate. Copy of a document showing your relationship to applicant. (marriage or birth certificate, power of attorney, military dependent card, medical treatment form, etc.)

Agreement

Note: Services are rendered at no charge to applicants.

I have read the Conditions of Acceptance and/or had them explained to me. I understand and agree to comply with all of the conditions of the South Carolina Equipment Distribution Program (SCEDP). I promise that the information I have provided is true and accurate to the best of my knowledge. I also understand that SCEDP may make certain information available to the South Carolina Legislature or other entities for the purposes of program administration, improvement, evaluation or auditing.

SCEDP, ITS OFFICERS, AGENTS, EMPLOYEES AND AFFILIATES, MAKES NO WARRANTY, REPRESENTATION OR CONDITION OF ANY KIND REGARDING THE PRODUCTS CONTAINED HEREIN AND/OR PROVIDED THROUGH OR BY SCEDP, AND ANY WARRANTY, EXPRESS OR IMPLIED, IS EXCLUDED AND DISCLAIMED, INCLUDING, BUT NOT LIMITED TO, THE IMPLIED WARRANTIES OR MERCHANTABILITY AND FITNESS FOR A PARTICULAR PURPOSE.

Applicant or Guardian Signature__________________________________Relationship to Applicant________________

For help installing or using equipment, please contact us at any of the telephone numbers listed at the top of this form.

Send form & documents to: SCEDP, 101 Executive Center Dr., Suite 120, Saluda Bldg., Columbia, SC 29210

Approved:______ Date:__________ (SCEDP only)

Certification on Reverse ➔

Certification

Administered by the South Carolina School for the Deaf and the Blind

Instructions Please print clearly in blue or black ink.

TO THE APPLICANT: Please deliver this form to a licensed professional certifier, who will complete and return the form to you. For help finding a professional certifier, please contact SCEDP.

TO THE CERTIFIER: The applicant is requesting specialized telecommunications equipment. Please verify that the applicant's disability prevents or causes a reduced ability to use a standard telephone. If you have any questions, please call SCEDP.

Applicant Information

First Name:________________________________ MI:_________ Last:_____________________________________

Home Phone: ______-______-________TTY / voice (circle one)

Disability Information Check all disabilities to be certified.

❑ Deaf ❑ Hard of Hearing ❑ Deaf-Blind ❑ Blind/Low Vision with Hearing Loss ❑ Speech Impaired

Braille User? ❑ yes ❑ no

The applicant's disability is ❑ permanent ❑ temporary with an estimated duration of_____________________

Certifier Information

Certifier First Name:_________________________ Last:____

Office Phone: ______-______-______TTY / voice (circle one) Email Address:________________________________

Address:_________________________ City:___________________ County:___________State:_____ Zip:_________

State License or Certification Number:____

Your Profession:

❑ Audiologist
❑ Doctor/Physician
❑ Physician Assistant (PA)
❑ Advanced Practice Registered Nurse (APRN)
❑ Speech-Language Pathologist
❑ Hearing Aid Specialist

Certification Sign and return this form to the applicant.

I affirm that the above named individual meets the certification requirements of being deaf, hard of hearing, speech impaired or dual sensory disabled as stated above.

Certifier Signature:____ Date:____________________

Certifier Notes Use this space to provide any additional information.

Application on Reverse →