Maryland Accessible Telecommunications

Equipment Distribution Program

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301 W. Preston St. Suite 1008A
Baltimore, MD 21201

800-552-7724 | 410-767-7253 (Voice/TTY)
410-801-9618 (Video Phone)
MAT.Program1@Maryland.gov
MDRelay.org

CHANGING Maryland *for the Better*

Maryland
DEPARTMENT OF DISABILITIES

MAT Applicants:

1. Please complete Parts 1, 2, 3 and 4 of this application (pages 3 through 13).

2. Detach pages 13 and 15, along the perforation. Complete the first section of Part 5, the Disability Certification Form, and give this form to your doctor, audiologist, rehabilitation counselor, speech pathologist, social worker, psychologist, mental health counselor, registered nurse, licensed practical nurse, or physical therapist to complete and return directly to MAT. If documents are too large, tape the prepaid label to the front of a separate envelope.

3. Make a copy of your required eligibility documents (do not send the original documents; they will not be returned). The copied eligibility forms can be folded and taped inside of your completed application, and sent directly to MAT showing the pre-paid, addressed panel on the outside.

4. Applicants are encouraged to make a copy of their entire application for personal reference.

If you prefer to e-mail your application and documentation, it can be sent to: MAT.Program1@Maryland.gov

MAT Application Part 1

Please print. Please use ink.

Last Name

First Name MI

Mailing Address (must not be a PO box) Apt.

City State Zip Code

____ ____ ____ ____ _____

Social Security Number (last 4 digits) Date of Birth: mm/dd/yyyy

E-mail Phone Number

Circle all that apply:

Voice Captioned Telephone
HCO STS Video

Your county *(check one)*:

☐ Allegany	☐ Carroll	☐ Harford	☐ St. Mary's
☐ Anne Arundel	☐ Cecil	☐ Howard	☐ Somerset
☐ Baltimore City	☐ Charles	☐ Kent	☐ Talbot
☐ Baltimore County	☐ Dorchester	☐ Montgomery	☐ Washington
☐ Calvert	☐ Frederick	☐ Prince George's	☐ Wicomico
☐ Caroline	☐ Garrett	☐ Queen Anne's	☐ Worcester

No phone? Can't use the phone? Under 18 years of age? Have a guardian? Let us know who we can call.

Name _____ Relationship _____

Phone Number _____

Circle all that apply:

Voice Captioned Telephone HCO STS Video

Your means of communication–please check all that apply:

☐ Voice ☐ Read lips ☐ ASL

☐ Signed English ☐ Written notes ☐ Typed

☐ Braille ☐ Augmentative and alternative communication (AAC)

Applied before?

☐ No ☐ Not sure ☐ Yes–what year? _____

How did you learn about us? (Please provide information such as name of the event, publication, etc.)

☐ Television Ad _____

☐ Digital Ad _____

☐ Printed Publication _____

☐ Conference _____

☐ Referral _____

☐ Community Event _____

☐ Family or Friend _____

☐ Other _____

Are you interested in receiving our newsletter?

☐ Yes ☐ No

If yes, what is your preferred delivery method? ☐ **E-mail** ☐ **Mail**

E-mail address: _____

(If different than the e-mail provided on page 3)

DO YOU (if yes, put a check)

☐ Have landline telephone service in your home now?
If not, have you applied to get telephone service? ☐ Yes ☐ No

☐ Have Internet service in your home now?
If not, have you applied to get Internet service? ☐ Yes ☐ No

Receive one of the following:

☐ Social Security (SSA)

☐ SSI (Supplemental Security Income)

☐ SSDI (Social Security Disability Insurance)

Please include a copy of your most recent Social Security Administration Award Letter.

OR

☐ Veterans (VA) benefits

☐ Temporary Disability Assistance Program (TDAP)

☐ Temporary Assistance for Needy Families (TANF)

☐ Pharmacy, medical, or housing assistance

Please include the most recent copy of paperwork as proof of eligibility.

OR

☐ Live on a limited or fixed income

Please include 2 most recent pay stubs, OR; unemployment pay stubs, OR; last year's income tax forms.

How many members are in your household? _____

ALSO INCLUDE:

☐ Copy of your telephone bill, Internet bill, or other utility bill

☐ Copy of your Maryland issued photo ID, driver's license, or identification card

PLEASE DO NOT SEND ORIGINALS (they will not be returned)!

MAT Application Part 3, Statement of Terms and Conditions for Acceptance of State Property for Personal Use

I understand and agree to the following:

1. The equipment is loaned to me for my personal use to access the telephone and I may use it for as long as I am a resident of this State. The conditions of my use are: (1) I will not sell, pawn, give away, loan it, or otherwise transfer my rights I might have to this equipment to others and (2) I will comply with all of the terms and conditions of this statement which I voluntarily agree to sign.
2. I understand if the equipment is damaged, I may be required to pay for repairs or replace the equipment.
3. If the equipment is damaged, I will NOT try to repair or disassemble equipment. I will return equipment to the vendor. I understand if I try to repair or disassemble equipment, it will void the manufacturer's warranty and I will be required to pay for repairs or replace the equipment.
4. When equipment repair is needed due to NORMAL WEAR & TEAR, at the MAT office's discretion, it will be provided to me at no cost. I must send the equipment back to the vendor for service.
5. If my equipment is STOLEN, I will report it to the police immediately. I will send a copy of the police report to the MAT office immediately. I cannot be issued a replacement until I have done this. I understand that the State may NOT give me another piece of equipment if stolen.

6. If I LOSE my equipment, I must report the loss to the MAT office immediately. I understand that the State may NOT give me another piece of equipment if lost.

7. I am solely responsible for use of the equipment and such use is at my sole risk and expense. I am solely responsible for any information, including confidential and personally identifiable information, I store on the equipment, or I provide to others by use of equipment, including ensuring the accuracy, authenticity, completeness and compliance with applicable law governing my use of the equipment, and for all related liabilities and responsibilities. Neither I nor any other person has the right to assert any claim or cause of action against the State of Maryland as a result of or in connection with the use of, or inability to use, the equipment. If the State of Maryland incurs any liability as a result of my use, or inability to use, the equipment, I will indemnify the State of Maryland to the full extent of any such liability.

8. It is against the law to file false statements regarding lost, damaged, or stolen State property. I understand that false statements filed by me can result in me being criminally prosecuted. I understand that if I SELL or PAWN the equipment, I can be criminally prosecuted. I understand and agree to defend, indemnify, and hold harmless the State of Maryland, and its units, agents, agencies, departments, officials, representatives, and employees from any and all claims, damages, and expenses of whatever nature arising out of use or misuse of equipment by me or any person of equipment given to me for my personal use. I further understand and agree that the State of Maryland, and its units, agents, agencies, departments, officials, representatives, and employees are not responsible for equipment furnished by the supplier of the equipment, for any acts of omissions of the supplier or the manufacturer of the equipment. Any claims or disputes over the equipment may be asserted solely against the supplier or the manufacturer of the equipment. The State shall not be considered a seller of the equipment and shall not be considered in any way a party to any transaction(s) between the customer and the supplier or manufacturer of the equipment.

9. Failure to comply with these Conditions of Acceptance may result in my being denied the privilege of having specialized telephone access equipment provided by the State of Maryland.

10. Upon approval of an application form, I will be notified of acceptance in writing. If necessary, I will request training specific to the device I will receive. If I am a minor, a parent/guardian will accompany me to the required training to sign this statement. If I am physically unable to attend training, I can call 800-552-7724 or 410-767-7253 (Voice/TTY) 410-801-9618 (Video Phone) to arrange for alternative site training. If an upgraded device is needed due to worsening health conditions, I must get a letter from my doctor, audiologist, speech language pathologist, or physical therapist, and I will send a copy of the letter to the MAT office.

Having read all of the above and below conditions or having them read and explained to me, I agree to comply with all of the terms and conditions of this program. I affirm that I am, or the minor for whom I am signing is, eligible to receive the requested equipment, having (1) provided the required medical certification of disability; (2) met the income guidelines by currently receiving a form of income identified in Part 2 (page 4) of the application; (3) signed the statement of terms and conditions for acceptance of State property; and (4) confirmed that I am, or the minor for whom I am signing is, not receiving similar equipment through other State or Federal agencies, or departments.

Print Name

Signature Date

(Applicant or parent/guardian, if under 18 years old)

Name of Witness

Signature Date

Authorization for Release of Medical Information

Last 4 Digits of Social Security Number:

___ ___ ___ ___

Date of Birth:

_____ - _____ - _____
Month Day Year

1. In accordance with Maryland's Health General Article §4-303, I authorize the use or disclosure of the above-named individual's health information as described below.

2. The following individuals or organizations are authorized to make the disclosures. (If you are an applicant with speech difficulties, we encourage you to please only include your speech language pathologist's information, if you have one. If you are an applicant with limited mobility, we encourage you to please only include your physical therapist's information, if you have one.)

   Name of physician or heath care professional completing Disability Certification Form:_____

   Address:_____

   Phone Number:_____

3. The health informant may be disclosed to and used by Maryland Accessible Telecommunications (MAT), 301 W. Preston Street, Suite 1008A, Baltimore, Maryland 21201 and contracting organizations for the purpose of the application for an evaluation of Maryland Accessible Telecommunications equipment.

4. The type and amount of information to be used or disclosed is as follows:

   a. Hearing b. Vision c. Speech d. Mobility e. Cognition

5. I understand I may inspect or copy the information to be used or disclosed. I understand any disclosure of information carries with it the potential for an unauthorized re-disclosure and the information may not be protected by federal confidentiality rules.

6. This authorization shall expire one year after the date of its execution.

If I have questions about disclosure of my health information, I can contact Maryland Accessible Telecommunications and speak with a representative.

_____

Print Name

_____

Signature Date

(Applicant or parent/guardian, if under 18 years old)

_____

Name of Witness

_____

Signature of Witness Date

Include pages 1 through 11 of your application along with copies of eligibility documents. Please carefully fold and use tape sparingly to close before mailing.

NO POSTAGE
NECESSARY
IF MAILED
IN THE
UNITED STATES

BUSINESS REPLY MAIL
FIRST-CLASS MAIL PERMIT NO. 2114 BALTIMORE, MD

POSTAGE WILL BE PAID BY ADDRESSEE

MARYLAND ACCESSIBLE TELECOMMUNICATIONS
301 W PRESTON ST STE 1008A
BALTIMORE MD 21298-7989

MAT Application Part 5

Please detach along the perforation, complete page 13, and give this form to your doctor, audiologist, rehabilitation counselor or speech pathologist to complete and return directly to MAT.

Disability Certification Form

Applicant: Please complete this part and give the form to your doctor, audiologist, rehabilitation counselor, or speech pathologist.

Applicant's Name Date of Birth: mm/dd/yyyy

Address Apt.

City State Zip Code

___ ___ ___ ___
Social Security Number (last 4 digits)

I authorize MAT to have access to and use information contained in this Disability Certification Form.

Applicant's Signature Date

PROFESSIONAL CERTIFICATION SECTION

Note to Health Care Provider: This form must be filled out by a practicing licensed professional as listed below, acting within the scope of his or her license, or by an authorized representative of a state agency or educational institution approved by Telecommunications Access of Maryland.

I certify that the above named person has impairment(s) marked below and is limited in his/her ability to use a standard phone.

Signature:_____Date:_____

Printed name:_____

Check one:

☐ Physician ☐ Audiologist ☐ Rehabilitation Counselor ☐ Speech Language Pathologist
☐ Social Worker ☐ Psychologist ☐ Mental Health Counselor ☐ Registered Nurse (RN)
☐ Licensed Practical Nurse (LPN) ☐ Physical Therapist
☐ Other health care professional *(specify)*_____

Office Address:_____

City, State, Zip Code:_____

Phone Number: _____State Lic/Cert #_____

DISABILITY (check all that apply)

☐ **Deaf/Deafened** – severe to profound hearing loss; cannot benefit from telephone amplification

☐ **Hard of Hearing** – needs amplification to effectively use a telephone
Hearing loss is: ☐ **mild** ☐ **moderate** ☐ **severe**

☐ **Low Vision/Blind** – vision with correction is 20/200 or less in the better eye, or the visual field is 10 degrees or less

☐ **DeafBlind** – severe to profound hearing loss and vision with correction of 20/200 or less in the better eye, or the visual field is 10 degrees or less

☐ **Speech Difficulty** – unable to speak intelligibly, or requires amplification to be heard on the phone

☐ **Limited Mobility** – ☐ upper body ☐ lower body ☐ both – impaired ability to grip, lift, hold, or dial the telephone, or impaired ability to get the phone when it rings

☐ **Cognitive Difficulty** – impaired ability to dial a series of numbers, to access (or memorize) a list of phone numbers, or to use the phone to get emergency services

Note to Licensed Health Care Provider

This form can be faxed directly to 410-767-4276. Or scanned and e-mailed to MAT.Program1@Maryland.gov.

Questions? Call Customer Service at **800-552-7724** or **410-767-7253** (Voice/TTY) **410-801-9618** (Video Phone).

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