Telecommunication Adaptive Devices (TAD) Application

Applicant Name: _____ Date of Birth: ____/____/____ Age: _____

Physical Address: _____

City/State/Zip: _____

County of Residence: _____ Email: _____

Primary Phone: _____Secondary Phone: _____

Gender: Male _____ Female _____

Race: Caucasian ____ | Native American ____ | Hispanic ____ | Asian American ____ |

African American ____ | Other: _____

Who else can we contact to reach you?_____ Phone: _____

How Did You Hear About TAD? (Check All That Apply)

___ Previous Applicant ___ Family/Friend ___ Medical Professional ___ Internet Search

___ Booth Event ___ VR/SBVI Referral ___ Other: _____

Do You Have Access to Telecommunication Services? _____Yes _____No

Type of service used: ___Landline ___Internet ___Cell Service ___Other: _____

DISABILITY ELIGIBLITY

For TAD consideration, diagnosis can't be Deafness, Deaf/Blind, Hard of Hearing, or Speech Impairment.
Please include documentation of the disability with application.

Diagnosis(es): _____

_____

Explain the need for a specialized telecommunication device: _____

_____

_____

_____

Check the category below that best defines the applicant:

_____Mobility (*orthopedic, stroke, arthritis, other physical*)

_____Cognitive/Intellectual (*stroke, traumatic brain injury, developmental disability, autism, etc.*)

_____Visual Impairment *(applicants identified as having a vision loss should be referred to SBVI)*

_____Other: _____

INCOME ELIGIBILITY

NOTE: Complete only if applying for a device over $500 or a mobile personal emergency response device. Income guidelines apply to all iDevices.

____ Check if device is under $500 and does not require income eligibility.

Total Number of Members in Household:_____

Complete the table below with income information including ALL members of the household.

Type of Income	Annual Amount		2024 Federal Poverty Guidelines	
Gross Wages	$		Family Size	400%
Self-Employment	$		1	$60,240
Social Security: SSI or SSDI	$		2	$81,760
Pensions	$		3	$103,280
Public Assistance	$		4	$124,800
Unemployment/Worker's Compensation	$		5	$146,320
			6	$167,840
			7	$189,360
TOTAL	$		8	$210,880

Please include the following documentation showing income, if applicable:

- Income or wage statements including: pay statements, social security, unemployment, Public assistance or other statements verifying money received by the family. Include at least 3 consecutive statements. OR
- Most recent federal tax form (1040 Tax Return)

I affirm that the information provided is complete and correct to the best of my knowledge.

_____ _____ _____

Date Applicant's Signature Guardian or Parent (if applicable)

Please return application and supporting documents by mail, email, or fax:

Division of Rehabilitation Services
811 E 10th Street Dept. 21 Sioux Falls, SD 57103

Email: Hailey.Bowers@state.sd.us
Fax: (605) 367-5327

AGENCY USE ONLY

____Eligible: ____Ineligible: identify the reason for ineligibility:_____

I certify that the information on this application is complete and correct.

_____ _____/_____/_____ SBVI – WRIL - ILC – DL

Signature of Approved Provider Staff Date Circle Your Agency

Equipment Provided (it is necessary to show the cost only if the device is purchased by the provider)

Type of Device	Description	Cost
Emergency Response System		
Large Button Phone		
Picture Phone/Dialer		
Remote Control Speakerphone		
iPad/ iPhone		
Other		
TOTAL		