# Missouri Assistive Technology LogoSpecialized Apps Pilot SFY 24- Missouri Assistive Technology

In State: 800-647-8557 (V) 800-647-8558 (TTY)

Out of State: 816-655-6700 (V) 816-655-6711 (TTY)

Email for TAP for Telephone: [motapwireless@gmail.com](mailto:motapwireless@gmail.com)

All information for the applicant should be in PRINT except where noted.

## Part 1: Applicant Information

Social Security Number (New applicants must include full SS, previously approved applicants provide last 4 of SS): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Applicant Name: (**Last**, First, MI): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Preferred Name (nickname): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date of Birth: Use 2 digit month, 2 digit day, and 4 digit year: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

What is the Disability: Hearing Vision Mobility Speech Learning/Cognition

Applicant’s email address: (required) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

## Part 2: Eligibility

I am a Missouri Resident: Yes No My Yearly adjusted gross income is: $\_\_\_\_\_\_\_\_\_\_\_\_\_\_ How many people are in your household? \_\_\_\_\_\_\_\_

## Part 3: Applicant Signature and Information Release

The above facts are true and complete to the best of my knowledge. Upon request, I will provided verification of the above information. If I should need further assistance with my request, I authorize TAP to release my name, address, and phone number to a consumer support provider.

Printed Name of Applicant or Guardian: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date of completion: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

## Part 4: Outreach (please choose one)

How did you learn about TAP: Previous applicant, Relay Mo, Rural Missouri Ad, Referred by Government Agency, Referred by Health Care Professional other than government, Word of Mouth, Community Event, Employer, Other (explain if other), \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

## Part 5: Certification- Only the following are approved for certifying this document: MD, DO, OD, SLP, Audiologist, Rehab Service for the Blind, Vocational Rehab, or TAP approved Agency:

To be completed by Certifying Authority Contact Address

|  |  |  |
| --- | --- | --- |
| Printed Name |  | Feel Free to use Return Label, Address Return stamp, attach business card, or print legibly the full address. |
| Signature |  |  |
| License Number (full) |  |  |
| Telephone: | ( ) |  |
| Email: |  | Date Certifier Signed: |

## Part 5b: Request

I understand that I am requesting an iTunes card or Google Play Store card with the intention to purchase specialized apps related to my disability so that I can participate in advanced distance communications. I have indicated those apps I am interested in purchasing on my application form.

I am requesting the card be in the amount of (indicate requested amount): $10 $25 $50

Confirm the card is (indicate type): iTunes (Apple) Google Play Store (Android)

I have completed the on-line application: Yes No

## Return this form to: Mo TAP Telephone, 1501 NW Jefferson St., Blue Springs, MO 64015

*To be considered, the TAP program requires both the on-line application and this certification form be completed.*