**

# Telecommunication Access Program for Internet (TAP-I)

# Application for Adaptive Computer Equipment

(816) 655-6700 (voice)

(816) 655-6711 (tty)

(816) 655-6710 (fax)

#  E-mail: sbrady@mo-at.org

## *Part 1 – Applicant Information (please print clearly)*

 Name (Last, First, Middle Initial):

 Delivery Address (Equipment is shipped UPS):

###  City, State, Zip Code:

######

####  Home Phone: Work Phone: Cell Phone:

####  Date of Birth: Social Security Number *(Last 4 digits Required):*

The following are requirements for requesting adaptive computer equipment through the TAP-I program. If you cannot answer “yes” to all of the following, contact the TAP-I program to discuss a possible referral.

 \_\_\_Yes \_\_\_No I am a Missouri resident.

\_\_\_Yes \_\_\_No My annual adjusted gross income is $60,000 or less for each individual or individual and spouse. (Add $5,000 for each additional dependent in the household.)

 \_\_\_Yes \_\_\_No I have Internet service in my residence. My provider is:

 \_\_\_Yes \_\_\_No I have an e-mail address: (Print clearly)

 \_\_\_Yes \_\_\_No I have a computer with: (Check the operating system on your computer. If your computer is older than listed below, it will not work with most current software.)

 \_\_\_ Windows 11 \_\_\_ Windows 10 \_\_\_ MAC \_\_\_ iPad

## *PART 2 – Equipment Selection*

You will be contacted upon the receipt of this completed and signed TAP-I application form.

To assist us in determining the level of support needed during the equipment selection process, please mark all of the following that apply to you.

\_\_\_ I have experience using a computer keyboard.

\_\_\_ I have experience using a computer.

\_\_\_ I *do know* the adaptive computer equipment I need for basic Internet access based on past experience and/or a trial period.

 PLEASE LIST:

 \_\_\_ I *do not know* what adaptive computer equipment I need for basic Internet access.

## *PART 3 – Disability Certification*

(To be completed by a licensed physician, speech pathologist, audiologist, hearing instrument specialist or a Missouri Assistive Technology approved agency representative.)

 I hereby certify that is unable to use traditional computer equipment for Internet access due to the disability indicated below.

 Low Vision Blind Vision and Hearing

 Reading decoding and/or comprehension disability - Briefly describe:

 Physical disability - Briefly describe:

 Other disability - Briefly describe:

 Please check the appropriate certification category below:

 Physician \_\_\_Speech Pathologist \_\_\_Audiologist \_\_\_Hearing Instrument Specialist

 (State License Number):

 Missouri Assistive Technology Approved Agency

 Certifying Agency:

 Date:

 Certifying Agent Printed Name:

 Certifying Agent Signature:

 Address:

 City: State: Zip Code:

 Telephone: E-Mail:

## PART 4 – Applicant Signature and Information Release

The above facts are true and complete to the best of my knowledge. Upon request, I will provide verification of the information provided. I authorize TAP for Internet to release my name, address, and phone number to a consumer support provider.

 Applicant or Guardian Signature Date

 Print Name & Relationship of person completing application (if other than applicant)

 Phone Number & Email

Mail, Fax, or Email completed and signed application to:

#####  TAP for Internet

##### 1501 NW Jefferson Street

##### Blue Springs, MO 64015

sbrady@mo-at.org Fax: 816-655-6710 (5/2025)