**

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