* Complete this form if you have previously received services from a TAP program OR
* The individual will be submitting medical records as proof of disability.
* Individuals may instead go to an approved center to complete the “Centers and Approved Professionals Certification”

TAP Wireless: State Fiscal Year 2025 **(July 1, 2024-June 30, 2025)**

## Complete:

**Print: Name of Applicant (Last, First, MI) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_­­­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_­­­­­­­­­­­­­­­­­­\_­­­\_**

**Date of Birth: MM/DD/YYYY ­­­\_\_\_\_\_\_\_\_­­­­­\_\_\_\_\_\_ Last 4 of Social Sec Number: ­­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

I have difficulty using basic or I require advanced distance communication equipment due to a disability of: (choose those that apply)

[ ] Vision [ ]  Hearing [ ] Mobility/Physical Access [ ] Cognitive/Memory

If the applicant has a speech disability contact Mo A T first [ ] Speech

Per my online application to TAP W, I am requesting the following (choose 1): Smartphone or Tablet

**Deaf or Hard of Hearing Applicants**: I would like a Visual Signaler as identified in my application (circle) Yes No

As an applicant or guardian of the applicant applying for TAP Wireless, if the applicant is approved for equipment:

* It is required that the applicant participate in surveys and email for a minimum of 3 years.
* TAP Wireless provides equipment only.
* The applicant is responsible for the service (Wi-Fi, as well as cellular and Data), fees associated with equipment, additional add-ons or accessories.
* A two (2) year warranty is provided as part of the program, approved applicants are not eligible for new equipment for three (3) years from the date of receiving equipment. See TAP Wireless Guide for specifics of warranty.
* I have read the responsibilities and agree to the terms of the Wireless Pilot. Submitting false information is known as perjury and my application can be revoked, equipment requested to be returned, and I be made ineligible for future equipment.

| Printed Name |  | Signature |  | Date: |
| --- | --- | --- | --- | --- |

Guardian Signature if applicable: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Guardian Print \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date:\_\_\_\_\_\_

### Certification of Disability

TAP Program Coordinator is verifying the applicant is known to have a disability that requires adaptive phone equipment for the purpose of advanced distance communication. This applicant is either known personally by Program Coordinator of agency, has submitted medical records, or is a long time recipient of TAP services.

TAP Program Coordinator Verification:

| Printed Name |  | Signature |  | Date: |
| --- | --- | --- | --- | --- |

Return this form and additional documentation to:

Email: motapwireless@gmail.com

Fax: 816-655-6710 ATTN: TAP Wireless

Postal Mail: **TAP Wireless, 1501 NW Jefferson St, Blue Springs, MO 64015**

**Reminder: include with your certification your:**

* **Medical Diagnosis related to your disability (if applicable)**
* **Household Income (required)**