Oregon

Kate Brown, Governor

Public Utility Commission
Residential Service Protection Fund
Telephone Assistance Programs
201 High St SE Suite 100
Salem, OR 97301-3612
Mailing Address: PO Box 1088
Salem, OR 97308-1088
1-800-848-4442
TTY: 1-800-648-3458
Fax: 1-877-567-1977
Web: www.rspf.org
Email: puc.rspf@state.or.us

Dear Applicant,

Thank you for your interest in obtaining a speech generating device (SGD) from the Telecommunication Devices Access Program (TDAP). Our goal is to loan these devices to eligible customers who have a severe or greater speech impairment. Due to a cap on funding, we will provide SGDs on a “first come, first served” basis.

Before you submit your application for a speech generating device, we encourage you to take the following steps:

- *Explore the possibility of obtaining a SGD through private insurance, Medicaid or Medicare,*
- *Work with your American Speech-Language-Hearing Association (ASHA) certified speech-language pathologist (SLP) in selecting the SGD that best meets your needs and*
- *Contact the manufacturers or vendors for assistance in selecting a SGD. (See page 1 of the enclosed application.)*

Please complete and sign Section A on page 2 and 3 of the application. Make sure your SLP completes and signs Section B on page 4 and 5. We look forward to working with you.

If you have any questions or concerns, please contact us using any of the methods listed above Monday through Friday, 9 a.m. to 4 p.m.

Sincerely,

TDAP Staff

Oregon Telecommunication Devices Access Program (TDAP)
Speech Generating Devices Application

AVAILABLE SPEECH GENERATING DEVICES

Vendor	Speech Generating Device	Access Methods
Prentke-Romich	• Accent 800 • Accent 1000 • Accent 1400 • PRio • PRio Mini	• NuEye • NuPoint
Teltex	• iPad • iPad Mini • iPad Pro (11”) • iPad Pro (12.9”)	N/A
Tobii-Dynavox	• EM-12 • I-13 • I-16 • I-110 • SC Tablet • Indi 7	• PC Eye Mini • PC Eye Plus & Eye R • Gaze Interaction • EyeMobile Plus Access
Saltillo	• Nova Chat 5 Plus • Nova Chat 8 Plus • Nova Chat 10 Plus • Nova Chat 12 Plus • Chat Fusion 10 Plus • Nova Chat 5 Dedicated Plus • Chat Fusion 8 Plus • Chat Fusion 8 Plus with ChatPoint	• ChatPoint
Smartbox	• Grid Pad Go 8” • Grid Pad Go 10” • Grid Pad Pro 12” w/ mount plate	• Eyegaze - Irisbond Duo Eye Tracking Camera

Please contact the manufacturer for assistance in selecting a speech generating device.

VENDOR CONTACT INFORMATION

VENDOR	PHONE NUMBER	E-MAIL ADDRESS	WEB SITE
Prentke-Romich	1-800-262-1984	service@prentrom.com	www.prentrom.com
Teltex	1-888-515-8120	info@teltex.com	www.teltex.com
Tobii-DynaVox	1-800-344-1778	css@tobiidynavox.com	www.tobiidynavox.com
Saltillo	1-877-397-0178	info@saltillo.com	www.saltillo.com
Smartbox	1-844-341-7386	info@thinksmartbox.com	www.thinksmartbox.com

Speech Generating Devices Application

Oregon Public Utility Commission
PO Box 1088, Salem, OR 97308-1088
800-848-4442 or 503-373-7171 TTY:
800-648-3458
VP: 971-239-5845
Fax: 877-567-1977 or 503-378-6047
puc.rspf@state.or.us

Oregon Telecommunication Devices Access Program (TDAP)

www.rspf.org

SECTION A

Please Print Your Information and Sign on Page 3 (Required Information)

Please note you may be able to acquire a speech generating device through private insurance, Medicaid or Medicare. TDAP loans speech generating devices for phone access to eligible Oregonians who may otherwise be unable to obtain a speech generating device.

Name of Applicant *(Last, First, Middle)* | **Phone/Cell** ( ) – | Other phone ( ) –

Home Address | **Apt. #** | **City** | **ZIP**

County | Parent/Guardian Name *(If applicant is a minor)*

Mailing Address *(If different than above)* | Apt. # | City | ZIP

Applicant (or Parent/Guardian) Oregon Drivers License or ID # | **Applicant Date of Birth** | Email Address

(If you do not have an ODL or ID #, please contact TDAP)

Alternate Contact Name *(Last, First)* | **Relationship** *(e.g. spouse, friend, relative, or caregiver)* | **Phone/Cell** ( ) –

Mailing Address of Contact Person | **Apt. #** | **City** | **ZIP**

I authorize my certifying speech-language pathologist to release all appropriate and necessary medical information required for the sole purpose of selecting the most appropriate goods or services provided by the Oregon TDAP.

Yes ☐ **No** ☐

FM608SGD (Revised 07/28/2020)

Conditions of Acceptance and Agreement for TDAP Speech Generating Devices

Please *READ* and *SIGN* the form that indicates you understand and agree to comply with the following conditions upon acceptance of all TDAP Speech Generating Devices (Equipment):

- All Equipment is the property of the State of Oregon and I will use it in compliance with Oregon laws and regulations, including Oregon Administrative Rule Chapter 860 Division 033.
- I will not offer for sale, sell, give away, or loan any Equipment to anyone. I am financially responsible for any damage to any Equipment that is not caused by normal wear and tear or acts of nature or disaster. [Note: A price list of the most current prices for previously used and current Equipment is available upon request.]
- I am responsible for the appropriate care of all Equipment and will use it for accessing telephone and related services.
- I will not remove the protective case from the Equipment. I will not damage or deface the Equipment (e.g., removing any property of Oregon identifying labels, altering the laser etching, etc.).
- I understand that the Equipment may have a web filter installed to prohibit access to websites containing unlawful, adult or inappropriate content. The TDAP office and TDAP Vendors have my permission to monitor the Equipment to ensure proper use.
- I will return defective or damaged Equipment at the PUC's expense. The PUC will repair or replace the returned Equipment at its discretion.
- If any Equipment is stolen, I will notify the local law enforcement agency within 24 hours of the time the theft is discovered. I will provide a copy of the police report to the TDAP office within five (5) business days of the date that I reported the theft.
- If floods, storms, fire, or other acts of nature damage the Equipment, I will submit a fire department, insurance, police or other appropriate report about the event to the TDAP office within five (5) business days after the date the event occurred.
- If I move to another place in Oregon, I will report my new address to the TDAP office within thirty (30) calendar days of the move.
- I am responsible for the purchase of Equipment supplies, such as headphones, and the costs related to the use of the Equipment, such as Wi-Fi service.
- I will return all Equipment to the TDAP office before I permanently move out of Oregon. I am liable for the replacement cost of any Equipment I fail to return before moving out of Oregon.
- I will obtain written permission from PUC's TDAP Manager before I travel out of the State of Oregon with any Equipment for more than 90 days.
- If I have signed this Agreement on behalf of a minor or as a guardian for an adult, I will notify the TDAP office about a change in responsibility within five (5) calendar days of the event (for example, the minor reaches 18 or there is a change of guardian). I understand that TDAP will bill me for any Equipment if the minor does not sign a new Condition of Acceptance and Agreement within 30 calendar days after the minor's 18th birthday and I am responsible for paying that bill.
- **I understand that all Equipment is provided on a "first come, first served" basis and its availability is contingent upon adequate funding.**

All statements I have made in this application are true and correct to the best of my knowledge.

Signature of Applicant or Parent / Guardian (If Applicant is under 18) **Date**

*Please provide a copy of the Power of Attorney/guardianship documentation if signing on behalf of applicant.

SECTION B

PROFESSIONAL CERTIFICATION FORM

This section is ONLY to be completed by an ASHA certified speech-language pathologist.

IMPAIRMENT (CHECK ALL THAT APPLY)

Speech
- Moderate
- Severe
- No Usable Speech

Language
- Expressive
- Receptive
- Both

Other Impairments - *For TDAP Information Purposes Only*

Hard of Hearing/Deaf
- Mild
- Moderate
- Severe
- Profound

Mobility
- Upper
- Lower
- Both

Cognitive
- Mild
- Moderate
- Severe/Profound

SPEECH GENERATING DEVICE REQUEST

Primary Device Requested: _____

Access Method (if needed): _____

Secondary Device Requested: _____

Access Method (if needed): _____

SPEECH APP SELECTION (FOR IPADS ONLY)

If selecting an iPad, please provide the name of the speech app below and provide a justification for this request as an amendment to this application.

App Name: _____

Please continue to page 5 ➔

SECTION B CONTINUED

PROFESSIONAL CERTIFICATION FORM

Please provide the following information in detail as an amendment to the application:

I. Applicant's communication abilities:

a. Ability to communicate without use of a device
b. Previous experience with devices (if applicable)
c. Why are previously owned or issued devices no longer being used (if applicable)
d. Applicant's current means of communication

II. Selection of device:

a. List all devices considered and rationale for elimination
b. Rationale for selection of specific device
c. Indications for success with selected device
d. Describe the applicant's experience using the selected device (if applicable)
e. Rationale for selection of an alternate (secondary) device
f. Indications for success with alternate (secondary) device
g. Describe the applicant's experience using the alternate (secondary) device (if applicable)

III. Using the device:

a. Expectations for applicant's communication ability while using the device
b. Perceived duration of need to use the device
c. Plans for successful phone communication using the device
d. Speech-Language Pathologist's continuing plans to assist the applicant in using the device
e. Support necessary for applicant to be successful using the device (e.g. caregiver, family members, other professionals)

Required: ***I hereby certify that*** _____
(Applicant's Name – Last, First)

requires the use of a speech generating device to communicate effectively on the phone.

ASHA CERTIFIED SPEECH–LANGUAGE PATHOLOGIST

Name (Print or Type) _____ Title _____ ASHA License Number _____

Street _____ City _____ State _____ ZIP _____

Phone ( ) – _____ Fax ( ) – _____ Email Address _____

Signature _____ Date _____