Telecommunication Devices Access Program (TDAP) Application

www.tdap.oregon.gov

Oregon Public Utility Commission
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SECTION A

Please provide us with your information.
*Required fields

*Name of applicant (First, Middle Initial, Last) _____ *Date of birth / /

Parent/Guardian name (if applicant is a minor) _____

*Phone number ◯ Home ◯ Cell **or** Email address

*Home address _____ Apt.# _____ *City _____ *Zip code _____

Mailing address (if different than above) _____ Apt.# _____ City _____ Zip code _____

Shipping address (if different than above) _____ Apt.# _____ City _____ Zip code _____

*Oregon drivers license or ID# _____

We use your Oregon Driver's License or ID# to verify that you live in Oregon. If you do not have an ODL or ID#, please include a copy of your recent utility bill or benefits statement with your application.

SECTION B

Please provide us with contact information for someone who can get in touch with you if we are unable to.

*Contact person's name (First, Middle Initial, Last) _____ *Relationship (e.g., spouse, relative, caregiver, etc.) _____

*Phone number ◯ Home ◯ Cell Email address

*Mailing address of contact person _____ Apt.# _____ *City _____ *State _____ *Zip code _____

Please continue to next page.

SECTION C — Please select or write the order number or name of equipment you are requesting from the catalog.

***Equipment order number:** Choose on piece of equipment **or**

Write in the order number or name of equipment: _____

SECTION D — Please read and sign this form indicating you understand and agree to comply with the following conditions upon acceptance of all TDAP Equipment.

- All TDAP Equipment (Equipment) provided to me is the property of the State of Oregon for four (4) years from the Public Utility Commission's (Commission) purchase date. Until the Commission informs me the Equipment is no longer the property of the State of Oregon, I will assume that it is property of the State.
- I will use the Equipment provided to me in compliance with Oregon laws and regulations, including OAR Chapter 860, Division 33.
- I am responsible for the appropriate care of all Equipment and costs related to the use of all Equipment including, but not limited to: batteries and phone or internet service. I am financially responsible for any failure to comply with OAR 860-033-0535(4) - (8).
- I am financially responsible if any Equipment is lost.
- I will contact the Commission if any Equipment is in need of repair or replacement.
- I will return any duplicate Equipment to TDAP within 30 days of a request from the Commission.
- I will not sell, lease, give away, or loan any Equipment to anyone. I will not use any Equipment as collateral for a loan of any type or as a pledge for a pawn loan.
- I am financially responsible for any damage to any Equipment that is not caused by normal wear and tear or acts of nature, force majeure or acts of terrorism.
- If any Equipment is stolen, I will notify the local law enforcement agency in the jurisdiction where the theft occurred within 24 hours of the time the theft is discovered. I will submit a copy of the law enforcement agency report that describes the theft, includes the location, date, time of discovery and any witnesses' names, addresses and telephone numbers to the Commission within 5 business days of the reported date of the theft.

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

_____ / /

*Physical or digital 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.

Please continue to next page.

SECTION E

Please have an authorized authority complete this section and certify your disability.

***I am a licensed:**

- ☐ Audiologist
- ☐ Hearing aid specialist
- ☐ Speech-language pathologist
- ☐ State of Oregon vocational rehabilitation counselor
- ☐ Physician
- ☐ Physician assistant
- ☐ Nurse practitioner
- ☐ Optometrist
- ☐ Ophthalmologist
- ☐ State of Oregon rehabilitation instructor for the blind

***Applicant's Disability (Check all that apply within the scope of your practice, e.g., a speech-language pathologist may only certify a disability in speech.)**

- ☐ Deaf/Hard of Hearing
- ☐ Blind/Low Vision
- ☐ Cognition/Memory
- ☐ Mobility/Motor
- ☐ Speech

*Certifying authority's name (print clearly)

*State license or certification number

*Phone number – –

*Email address

*Address

*City

*State

*Zip code –

I hereby certify,

*Name of applicant (First, Middle Initial, Last)

has a disability that requires specialized equipment to effectively communicate on the phone.

*Physical or digital signature of certifying authority

*Date / /

SUBMIT FORM