DEPARTMENT OF HEALTH SERVICES
Division of Public Health
F-02306 (01/2021)

STATE OF WISCONSIN
Wisconsin Statute § 46.297

APPLICATION

Telecommunication Assistance Program (TAP)

NOTICE: Complete this application to apply for TAP assistance. Your application will be processed in the order it was received, and approved if you meet the program's income eligibility guidelines. Eligible applicants must provide documentation of hearing loss.

If you require assistance completing the application or have any questions about the program, please call the TAP office at 608-266-2536 or contact us by email at DHSTAP@dhs.wisconsin.gov. You can also visit our website at DHS TAP.

Name – Applicant (Last, First)	Phone Number	Date of Birth (mm/dd/yyyy)	
Address (Street)	City	State WI	Zip Code

TEPP Application Number (if known, otherwise leave blank).

Applying for: (check the box for the assistance you are applying for. Contact the TAP office for more information about these options.)

☐ TAP Copay ($100) ☐ TEPA (TAP Equipment Purchase Assistance, up to an additional $150) ☐ TAP Plus (up to a total of $250)

Household Annual Adjusted Gross Income $	Number of People in Your Household	Enter your most recent annual adjusted gross income for your household, as reported on your Wisconsin Income Tax Return, **OR** total of all household income, including spouse if applicable, Social Security, wages, SSI, and other benefits. Proof of income may be requested.

I am (check only one):

☐ Severely Hard of Hearing
☐ Deaf
☐ Deaf-Blind

I understand that I will need to include **ONE** of the following documents to complete my TAP application. Check applicable documentation:

☐ Audiogram from a certified audiologist.
☐ Hearing Loss Certification signed by a licensed physician **OR** certified audiologist.
☐ Hearing Loss Certification signed by a hearing instrument specialist **AND** documentation of hearing test that demonstrates the applicant's need for hearing instruments. Both documents need to be completed within six months of this application date. (Pursuant to Chapter HAS 4)

Voucher for telecommunication equipment assistance will be sent directly to the applicant, unless otherwise noted here.

☐ I authorize the TAP voucher to be sent to:

Name	Phone Number	Relationship to Applicant	
Address (Street)	City	State	Zip Code

NOTE DISCLAIMERS:

- A person eligible for or receiving services from the Department of Workforce Development's Division of Vocational Rehabilitation (DVR) shall first be evaluated by DVR to determine if the person is eligible for a telecommunication device under the vocational rehabilitation program, and if denied by DVR the person may apply for TAP assistance.
- Preference will be given to individuals who are not receiving telecommunication devices from another state program.

I certify that all information provided on this application, including information about applicant's disability and income, are true, complete, and accurate to the best of my knowledge. I authorize TAP program representatives to verify the information provided. I permit applicant's information to be exchanged as needed with internal and external agencies, organizations, or individuals as program policies dictate for the administration of the program and for the delivery of equipment and services to the above named applicant.
I agree and give consent? ☐ Yes ☐ No

Name – Person Completing this Form		Date Form Completed (mm/dd/yyyy)
Check appropriate box ☐ Applicant ☐ Parent ☐ Guardian/POA	Relationship, if not Applicant	Contact Phone Number

SUBMIT COMPLETED APPLICATION FORM BY MAIL OR FAX

Mail:
Office for the Deaf and Hard of Hearing
Attn: TAP
P.O. Box 2659
Madison, WI 53701-2659

Fax:
608-267-3203
Office for the Deaf and Hard of Hearing
Attn: TAP