DEPARTMENT OF HEALTH SERVICES
Division of Public Health
F-02306 (03/2024)

STATE OF WISCONSIN
Wisconsin Statute § 46.297

APPLICATION

Telecommunication Assistance Program (TAP)

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. The PII/PHI submitted is used only for the purpose of determining applicants eligibility for TAP assistance.

If you require assistance completing the application or have any questions about the program, please call the TAP office at 608-267-7195, contact us by email at DHSTAP@dhs.wisconsin.gov or visit our website at https://www.dhs.wisconsin.gov/odhh/tap.htm.

TAP applicants can only apply for TAP assistance once every three (3) years. TAP funding is limited and is on a first-come first serve basis. An online version of the application is also available at https://survey.alchemer.com/s3/5553665/TAP-Application.

Applicant First Name _____ **Last Name** _____

Self-identifying Category (Select one)
☐ Deaf ☐ Deaf/Blind
☐ Severely Hard of Hearing

Date of Birth (mm/dd/yyyy) _____

Address (include unit number if applicable) _____

City _____ **State** WI **ZIP Code** _____ **Phone Number** _____

Phone Type (Select all that apply)
☐ Text ☐ TTY ☐ Video Phone
☐ Voice ☐ Other - Write In: _____

What is your Household Annual Adjusted Gross Income? $_____

How Many Members Live in Your Household? _____

Enter your most recent annual adjusted gross income, as reported on your Wisconsin Income Tax Return, **or** the total of all taxable household income **and** provide the number of members living in your home. Proof of income may be requested.

How can TAP help you? Provide information about how TAP can help you, **including TEPP application number,** if available. Ex: "I need help paying TEPP copay for app #123456 or I need help with out-of-pocket costs for new phone/equipment".

I understand I must have one of the following documents on file with TAP to complete this application.

Select documentation you have or will be providing.

☐ An audiogram and/or Hearing Loss Certification F-22554 signed by a licensed physician **OR** audiologist.

☐ A Hearing Loss Certification signed by a hearing instrument specialist **including** copies of hearing tests results completed within six (6) months of the application date and performed pursuant to Chapter HAS 4 https://docs.legis.wisconsin.gov/code/admin_code/has/4) (see form for more information).

☐ A copy of my audiogram and/or signed Hearing Loss Certification F-22554 is already on file with TAP.

I authorize the TAP voucher to be sent to: (TAP vouchers will be sent directly to the applicant, unless otherwise noted here)

Person or Vendor Name _____ Phone Number _____ Relationship to Applicant _____

Address (include unit number if applicable) _____ City _____ State _____ ZIP Code _____

DISCLAIMERS: Preference will be given to individuals who are not receiving telecommunication devices from another state program. Contact the TAP Program Coordinator or visit the TAP website at https://www.dhs.wisconsin.gov/odhh/tap.htm for more information.

CONSENT: I certify that all information provided on this application, including information about 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 this information to be exchanged as needed with internal and external agencies, organizations, or individuals as needed to process my application to the program for financial assistance **I agree and give consent:** ☐ **Yes** ☐ **No**

Signature of Person Completing Application _____

Print Name: _____

Relationship to applicant:
☐ Applicant ☐ Parent ☐ Guardian ☐ Power of Attorney
☐ Other – Write in (required): _____

Please provide your contact information in case we have any follow-up questions.

☐ Same as above

Contact Phone Number or Email Address _____

Submit completed application and verification documentation, if applicable, to:

Mail: DHS ODHH TAP
P.O. Box 2659
Madison, WI 53701-2659

Fax: DHS ODHH TAP
608-267-3203

Email: DHS ODHH TAP
DHSTAP@dhs.wisconsin.gov