TEXAS Health and Human Services

Form 3907
October 2022-E

Office of Deaf and Hard of Hearing Services (ODHHS)

Application for Specialized Telecommunications Assistance Program (STAP) Speech Generating Devices (SGD)

Step 1 – Provide Applicant Information (the person using the equipment)

**** Denotes a required field.***

*Applicant Name		TX Driver's License No. or TX ID No.	*Date of Birth
*Street Address		*City	*State / *ZIP Code
*Area Code and Phone No.	Area Code and Fax No.	Email Address	

Mailing Address if different from above (P.O. Boxes are accepted):

Name			
If the mailing address is not the applicant's, specify the person's relationship to the applicant			
Address	City	State	ZIP Code
Parent or Legal Guardian's Name			

Signature

This application must have an original signature—not a photocopy, facsimile, or stamped signature. If you are under 18, your parent or guardian must sign the application.

The following statement must be signed before the application can be processed.

I attest to the following:

- The applicant is a Texas resident.
- The applicant is at least 5 years old.
- Due to a disability, the applicant requires a specialized telecommunications device to access the phone network.
- The device selected will enable the applicant to access the phone network.
- I understand that STAP may request additional documentation as needed to confirm or supplement any information provided on the application, including physician's statements or medical records.
- I understand that I have one year from the date the application is processed to provide any required additional information to receive a voucher before I must complete another application to apply for a voucher.
- I consent to the applicant speaking to a STAP representative after receiving the specialized telecommunications device to verify that the applicant can access the phone network with the device received.

_____ _____

Applicant, Parent or Legal Guardian Signature*
(must be original, not a photocopy, facsimile, or digital)

Date

*Printed Name	*Relationship to Applicant *(applicant, parent or legal guardian)*

Mail to: STAP, P.O. Box 12904, Austin, TX 78711

This application form is valid until Aug. 31, 2024.

hhs.texas.gov/services/disability/deaf-hard-hearing

Step 2 – Provide Proof of Residency

Include a copy of one of the following as proof of your Texas residency. Document must be current and dated within three months of the date the application is received.

- Texas Driver's License
- Voter Registration Card
- Utility Bill (showing address)
- Vehicle Registration Card
- ID Card with address
- Letter on the official letterhead of a residential facility signed by the facility director or supervisor

Note: Proof of residency must name the **applicant** or the **parent**, or the **legal guardian** signing the application **and** show the home address as it appears on the application.

Step 3 – Device Options

You must meet the established disability requirements for the device requested.

Note: These disability requirements are defined in the form instructions.

SI = Speech impaired **CI** = Cognitively impaired **UMI** = Upper mobility impaired

Telecommunication Device or Software	Disability Requirements
SGD Level 1 A hand-held device that generates digitized or synthesized speech using pictures.	(**SI** and **CI)** or (**SI** and **UMI**)
SGD Level 2 A device that generates digitized or synthesized speech using pictures.	(**SI** and **CI**) or (**SI** and **UMI**)
SGD Level 3 A device that generates digitized or synthesized speech using pictures that allow for eye control or head movement access.	**SI** and **UMI**
SGD Switch A device that connects to an SGD to allow the user to review and make selections.	**SI** and **UMI**
SGD Head Pointing or Movement Control Device A device that connects to an SGD to allow access to an SGD using head or other body movements.	**SI** and **UMI**
SGD Eye Control Access A device that connects to an SGD to allow access to an SGD using eye movements.	**SI** and **UMI**
SGD Mount A device used to secure an SGD.	**SI** and **UMI**
SGD Switch Mount A device used to secure an SGD switch.	**SI** and **UMI**
SGD Moisture Guard A protective moisture barrier for an SGD device.	(**SI** and **CI**) or (**SI** and **UMI**)
SGD Key Guard A protective overlay that helps to prevent inadvertent key activation.	(**SI** and **UMI**)
Infrared Telephone A phone that can be operated by infrared transmitted signals.	(**SI** and **CI**) or (**SI** and **UMI**)
Anti-Stuttering Device Provides the user with Delayed Audio Feedback (DAF) and Frequency Shifted Audio Feedback (FAF). If an applicant is not certified as having an UMI, a voucher may be issued at a lesser value.	**SI** and **UMI**
Speakerphone A phone with a speaker built into the base.	**SI** or **UMI** or **CI**

Step 4 — Provide a Professional Certification of Your Disability

A licensed speech-language pathologist (not an intern or an assistant) must complete this section unless only an anti-stuttering device is requested. A Texas Workforce Commission VR counselor may complete this form for an anti-stuttering device. Additional documents to supplement the pathologist's response may be attached. Please print clearly. Illegible information may be returned for clarification.

Applicant Name (the person using the equipment)	Applicant Date of Birth	Application No. (for ODHHS use only)

1a. Specify manufacturer and product name of device requested.

1b. Specify accessories requested, if any:

2. Describe how the equipment requested was selected. Include the names of all other devices that were tested during the evaluation and explain why they are not being requested.

3. Is the applicant reapplying for a voucher because of a change of disability? ◯ Yes ◯ No

If yes, Form 3926, Change of Disability, must be completed. Contact dhhs.phones@hhs.texas.gov for this form or print it from the ODHHS website at hhs.texas.gov/services/disability/deaf-hard-hearing (under Telephone Access).

4. Describe what the applicant can do with the requested equipment in relation to accessing the phone network. Information provided must demonstrate that the applicant is able to use the device and that the applicant is able to access the phone networks using the device.

5. With use of the requested device, describe the applicant's ability to:

a) Press an icon or combine icons to compose a message:

b) Compose a message through typing:

6. Provide a complete description of all limitations that interfere with the applicant's ability to use a standard phone.

a) cognitive status:

b) speech impairment status:

c) upper mobility status:

d) hearing status:

e) vision status:

Certification

As the certifier, I attest to the following:

- I am eligible to certify under the provisions of STAP.
- I have personally met with the applicant and have assessed the applicant's disability to determine that he or she is eligible, in accordance with the STAP eligibility criteria.
- I have determined that the applicant will be able to benefit from the specialized telecommunications device recommended above to access the phone network and that the applicant's age or disability does not prevent him or her from using the selected specialized telecommunications device to gain access to the phone network.
- I understand that STAP may request additional documentation from me, the applicant, or other sources to confirm or supplement any information provided on the application, including physician's statements, medical records, or a copy of my license or certificate.
- I understand that if I have violated or if I am suspected of violating any HHS policy or laws related to the STAP, including certifying applicants who cannot access the phone networks with the device requested, that I may no longer be authorized to certify applications, and that if I have committed or am suspected of committing such violations, I may be referred to my licensing agency.
- All information I have provided on this application is valid and accurate to the best of my knowledge.

Printed Name of Certifier		Speech Language Pathologist's License No.		
Name of Business				
Street Address		City	State	ZIP Code
Area Code and Phone No.	Area Code and Fax No.	Email Address		
Certifier Signature (must be original, not a photocopy, facsimile, or stamp):			Date:	