

Application

Telecommunication Assistance Program (TAP)

About this application

Use this application to apply for financial assistance through the Wisconsin Telecommunication Assistance Program (TAP). TAP helps eligible Wisconsin residents get specialized telecommunications equipment. Applications are processed in the order received. Funding may be limited. Preference will be given to individuals who are not receiving telecommunications equipment through another state program. Personally identifiable information (PII) collected on this form will be used only to determine eligibility for TAP.

To be eligible for TAP, you must:

- Live in Wisconsin.
- Meet TAP income eligibility requirements.
- Provide documentation of hearing loss.
- Not have received TAP funding within the past three years.

If you would rather complete this form online: <https://survey.alchemer.com/s3/5553665/TAP-Application>

Questions?

Email: DHSTAP@dhs.wisconsin.gov

Phone: 608-266-1161

Section 1: Applicant information

Name (First, MI, Last): _____ Date of birth: _____

Street address (including unit number, if any): _____

City: _____ State: _____ ZIP code: _____

Phone number: _____ Email: _____

Phone type (select all that apply):

☐ Text

☐ Voice

☐ TTY

☐ Other: _____

☐ Video Phone

Self-identifying category (select one):

☐ Deaf

☐ Deaf/Blind

☐ Severely Hard of Hearing

Section 2: Eligibility and assistance requested

Annual adjusted gross income: \$ _____

(Enter your most recent annual adjusted gross income, as reported on your Wisconsin income tax return or the total of all your household taxable income. Proof of income may be requested.)

Number of household members: _____

(Only household members that share financial support; roommates should not be included.)

Briefly describe how TAP can assist you: _____

(Example: "I need help paying the TEPP copay for app #123456." or "I need help paying for a new phone.")

To complete your application, TAP must receive one of the following (select one):

- ☐ Audiogram and/or Hearing Loss Certification (F-22554) completed by a licensed physician or audiologist.
- ☐ Hearing Loss Certification (F-22554) completed by a hearing instrument specialist and copies of hearing test results completed within the past six months pursuant to Chapter HAS 4.
- ☐ My audiogram and/or Hearing Loss Certification is already on file with TAP.

Section 3: TAP voucher delivery (optional)

Complete this section only if the TAP voucher should be mailed to **someone other than the applicant**.

Person or vendor name: _____ Relationship to applicant: _____

Street address (include unit number, if any): _____

City: _____ State: _____ ZIP code: _____

Phone number: _____ Email: _____

Section 4: Consent and signature

I certify that the information provided on this application, including information about my disability and income, is true, complete, and accurate to the best of my knowledge. I authorize TAP representatives to verify the information provided and to exchange information with internal and external agencies, organizations, or individuals as needed to process my application.

- ☐ Yes, I agree and give my consent.
- ☐ No, I do not agree or give my consent.

Note: This application will not be processed without consent.

Signature – Applicant or Authorized Representative: _____

Printed name: _____ Date signed: _____

Complete this section only if you completed this application **on behalf of the applicant**.

Relationship to applicant (select one, if applicable):

☐ Parent ☐ Guardian ☐ Power of Attorney ☐ Other: _____

Phone number: _____ Email: _____

Section 5: Submit this form

Submit the completed application using one of the following methods:

Email: DHSTAP@dhs.wisconsin.gov

Fax: 608-224-5754

Mail:

DHS ODHH TAP

10243 W. National Ave.

West Allis, WI 53227