AAA-1222A LTHPD (3-15)

DEPARTMENT OF ECONOMIC SECURITY
Your Partner For A Stronger Arizona

Douglas A. Ducey
Governor

Timothy Jeffries
Director

TELEPHONE ASSISTANCE PROGRAM
CLIENT INSTRUCTION SHEET

- Attached is the Telephone Assistant Program (TAP) Checksheet
  (**THIS FORM IS NOT AN APPLICATION**)

- Have your doctor complete the "Doctor's Office Only" and "Confirmation of Medical Need" sections

- Call _____ to set up an appointment with your local Family Service Center or Community Action Program (CAP) to have an application completed for Telephone Assistance Program and get a list of items that you need to bring with you to the appointment

- At the time of your appointment:
  Have your Telephone Assistance Program (TAP) Checksheet with the Confirmation of Medical Need section completed by your doctor and all other materials listed by your case worker ready.
- Your caseworker will complete the "Family Service Center or CAP Use Only" section of the Telephone Assistant Program (TAP) Checksheet.
- After you have completed the above instructions, your application will be sent to the Department of Economic Security, Division of Aging and Adult Services (DES – AAA) for processing. You will be notified of your eligibility by mail.
- Processing takes 30 to 45 days from the application date.

If you need further assistance or more information, please call
602-542-4446 or Toll Free 1-800-582-5706

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ARIZONA DEPARTMENT OF ECONOMIC SECURITY
Division of Aging and Adult Services

TELEPHONE ASSISTANCE PROGRAM (TAP) CHECKSHEET

The Department of Economic Security, Corporation Commission and Century Link are jointly administering a telephone assistance program in the state of Arizona**.** The program provides assistance for low-income persons with a medical need. The application process is being conducted jointly by the Department of Economic Security and local volunteer agencies. The program provides for the monthly basic rate, and assistance with installation costs if needed. We are asking for your assistance in the determination of medical need in order for the household to qualify for this benefit.

DOCTOR'S OFFICE USE ONLY
CONFIRMATION OF MEDICAL NEED

PATIENT'S NAME | PHONE NO.

PATIENT'S ADDRESS *(No., Street, Apt. No, City, State Zip Code)*

The patient has a medical condition that would require a telephone in the household. The medical condition will require the availability of a telephone for approximately:

☐ Up to one year ☐ Two years or less ☐ Three years

DOCTOR'S NAME | PHONE NO.

DOCTOR'S ADDRESS *(No., Street, Suite No., City, State, Zip Code)*

DOCTOR'S SIGNATURE | DATE

AGENCY USE ONLY
FAMILY SERVICE CENTER OR COMMUNITY ACTION PROGRAM (CAP)

YES	NO	
☐	☐	The home is wired for telephone service
☐	☐	Has the household had land-line telephone service in the past 90 days?
☐	☐	The doctor's signed statement indicates applicant's medical need.
☐	☐	The doctor's signed statement indicates applicant's medical crisis

The medical need will last *(check appropriate box):*

☐ Up to one year ☐ Two years or less ☐ Three years

YES	NO	
☐	☐	Is the caseworker providing certification for TAP? *(Worker certification is only valid for 1 year)*

WORKER'S SIGNATURE | DATE

If you have any questions regarding this form, please call the TAP office at 542-4446 or 1-800-582-5706.
THIS FORM IS ONLY VALID FOR 60 DAYS AFTER THE DOCTOR'S SIGNATURE DATE.
PLEASE, DO NOT MAIL THIS FORM. SEE INSTRUCTIONS ON REVERSE SIDE.