SPEECH APPLICANT INFORMATION

Last Name	First Name	Middle Name
Address		Apt. No.
City/State	Zip C	code/County
Age Group (Check	One): (5-17)	(18-54) (55 and up)
Telephone Number	r	_ Check One:
Email Address		
Marital Status: Si	ngle Married	Widowed
Number of Depend	ents:	
	-	
REL	EASE OF INFORM	ATION
I hereby request and authorize my behalf to/from GATEDP.	the following contac	ct to provide/obtain information on
Contact Name:	Cor	ntact Name:
Contact Number:	Cor	ntact Number:
Relationship:	Rela	ationship:
I am interested in obtaining more individual. I request and authoriz programs I would qualify for.	e information about progr e GCDHH to use the infor	rams that could benefit me as a low-income rmation provided above to screen for other
All information I hereby author strictly confidential.	ize to be provided/ob	otained to/by the above will be held
X		
Applicant Signature		

CERTIFICATE OF NEED (FOR USE BY SLP ONLY)

Please complete the following evaluation based on your knowledge of the client's need.

Communication Impairment Please indicate the client's type of speech impairment. Please describe the client's impairment severity (how the individual presents).				
	s of your client's speech es to an underlying dise	impairment and the expected ase/condition?	course of the speech	
	munication Needs with ed to receive a device fu	n Other Approaches nded by their insurance?	Yes No	
If so, what portion of t	the cost was the insuran	ce company willing to pay?		
•	pany would not cover the the co-pay? (Check one	e cost of the entire device,	Yes No	
Why is the patient un this particular device	-	onal telecommunication neec	ds without	
Clinician Information	<u>n</u>			
Last Name	First Name	Clinic Address		
Email Address		City, State, and Zip Code)	
Telephone Number		Fax Number		
I assert to my qualifica	ation under penalty of p	erjury that my above answers	are true and correct.	
V		V		

Date

Signature

2

APPLICANT CHECKLIST (THE FOLLOWING DOCUMENTS ARE REQUIRED FOR ELIGIBILITY)

APPLICATION AND CERTIFICATE OF NEED:	The sections labeled Applicant Information, Release of Information, and Certificate of Need found above.
PROOF OF INCOME:	Applicants must show proof that <u>all</u> of their annual income does not exceed 200% of the Federal Poverty Level. If married, both incomes are required. Sources of proof can include, but are not limited to, a governmental benefit check stub or letter, pay stub, or W-2 form. Proof of income must be from within the last calendar year at the time of applying.
PROOF OF PHONE OR INTERNET SERVICE:	Applicants must provide proof of cellphone, landline, or internet phone service. The applicant's most recent bill will suffice.
PROOF OF GEORGIA RESIDENCY:	Applicants must be a resident of Georgia. Applicant's driver's license, state ID, rental agreement, any utility bill, or a piece of mail from a government agency may be used to determine this requirement.

APPLICANT MAY SUBMIT FORM AND REQUIRED DOCUMENTS VIA:

Mail: 2296 Henderson Mill Rd NE

#115 Atlanta, GA 30345

Fax: 404-297-9465 Phone: 888-297-9461

Email: info@gcdhh.org