



Visual Smoke Alarm Subsidy Program

Application Form

PART A – APPLICANT INFORMATION

Please fill in one application form per household

CONTACT INFORMATION

Please provide the following contact information

Name:

Postal Address:

Town/Suburb:

Postcode:

Phone:

- TTY
- Voice

Mobile:

- SMS
- Voice

Fax:

Email:

Preferred method of contact:

- Phone
- Mobile
- Fax
- Email

NUMBER OF VISUAL SMOKE ALARMS REQUESTED

You can apply for more than one smoke alarm per household, where people who are Deaf or Hard of Hearing sleep in separate bedrooms e.g. flatmate or family living in the same house.

How many visual smoke alarms do you need in your house? _____

Please note: each visual smoke alarm costs \$50.00

REQUEST FOR AUSLAN INTERPRETER

Do you need an Auslan interpreter to help you communicate with the person from the Tasmania Fire Service when they visit your home to install the visual smoke alarm?

- Yes
- No

INFORMATION ABOUT THE APPLICANT**Please provide the following personal information**

Date of Birth: ____ / ____ / 19____	Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female
Country of Birth:	Are you of Aboriginal or Torres Strait Islander origin? <input type="checkbox"/> Yes <input type="checkbox"/> No
Do you live in: <input type="checkbox"/> Your own property <input type="checkbox"/> A rental property <input type="checkbox"/> Department of Housing accommodation (e.g. public housing) <input type="checkbox"/> Disability funded accommodation (e.g. a community residential unit) <input type="checkbox"/> Other	What is your preferred method of communication? <input type="checkbox"/> Auslan (Australian Sign Language) <input type="checkbox"/> Other Sign Language <input type="checkbox"/> Spoken English <input type="checkbox"/> Other Spoken Language <input type="checkbox"/> Other
Type of hearing loss: <input type="checkbox"/> Mild Loss <input type="checkbox"/> Moderate Loss <input type="checkbox"/> Severe Loss <input type="checkbox"/> Profoundly Deaf	If aged 16 years or more, what is your main source of income? <input type="checkbox"/> Paid employment <input type="checkbox"/> Pension <input type="checkbox"/> Other
Are you a Health Care Card holder? <input type="checkbox"/> Yes <input type="checkbox"/> No	Do you receive individualised funding under the Disability Services agreement? <input type="checkbox"/> Yes <input type="checkbox"/> No
Do you have a carer? <input type="checkbox"/> Yes <input type="checkbox"/> No	Department of Veteran's Affairs client? <input type="checkbox"/> Yes <input type="checkbox"/> No

INFORMATION ABOUT ALL OTHER OCCUPANTS IN THE HOUSEHOLD**Please provide the following information about the other people that live in your household****Additional occupant # 1:**

Age	Hearing loss	Method of communication	Health Care Card holder
<input type="checkbox"/> Under 18	<input type="checkbox"/> Hearing	<input type="checkbox"/> Auslan	<input type="checkbox"/> Yes
<input type="checkbox"/> 18 - 24	<input type="checkbox"/> Mild Loss	<input type="checkbox"/> Other Sign Language	<input type="checkbox"/> No
<input type="checkbox"/> 25 - 44	<input type="checkbox"/> Moderate Loss	<input type="checkbox"/> Spoken English	
<input type="checkbox"/> 45 - 64	<input type="checkbox"/> Severe Loss	<input type="checkbox"/> Other Spoken Language	
<input type="checkbox"/> 65 +	<input type="checkbox"/> Profoundly Deaf		

Additional occupant # 2:

Age	Hearing loss	Method of communication	Health Care Card holder
<input type="checkbox"/> Under 18	<input type="checkbox"/> Hearing	<input type="checkbox"/> Auslan	<input type="checkbox"/> Yes
<input type="checkbox"/> 18 - 24	<input type="checkbox"/> Mild Loss	<input type="checkbox"/> Other Sign Language	<input type="checkbox"/> No
<input type="checkbox"/> 25 - 44	<input type="checkbox"/> Moderate Loss	<input type="checkbox"/> Spoken English	
<input type="checkbox"/> 45 - 64	<input type="checkbox"/> Severe Loss	<input type="checkbox"/> Other Spoken Language	
<input type="checkbox"/> 65 +	<input type="checkbox"/> Profoundly Deaf		

Additional occupant # 3:

Age	Hearing loss	Method of communication	Health Care Card holder
<input type="checkbox"/> Under 18	<input type="checkbox"/> Hearing	<input type="checkbox"/> Auslan	<input type="checkbox"/> Yes
<input type="checkbox"/> 18 - 24	<input type="checkbox"/> Mild Loss	<input type="checkbox"/> Other Sign Language	<input type="checkbox"/> No
<input type="checkbox"/> 25 - 44	<input type="checkbox"/> Moderate Loss	<input type="checkbox"/> Spoken English	
<input type="checkbox"/> 45 - 64	<input type="checkbox"/> Severe Loss	<input type="checkbox"/> Other Spoken Language	
<input type="checkbox"/> 65 +	<input type="checkbox"/> Profoundly Deaf		

CONSENT FOR YOUR INFORMATION TO BE PROVIDED TO PARTNERING AGENCIES

All information collected by Tasdeaf must be kept strictly confidential. All clients accessing Tasdeaf services and programs are assured that their personal information will not be disclosed to others unless the client has authorised Tasdeaf staff to do so. Signed consent is requested to provide authorisation for Tasdeaf to give your information to other agencies.

Do you give consent for Tasdeaf to provide your details to partnering agencies involved in the Visual Smoke Alarm Subsidy program – eg. the Tasmanian Fire Service and the Tasmanian Department of Health & Human Services (DHHS)?

Yes No

Do you give consent for the Tasmanian Fire Service to contact you (using your preferred method of contact) to schedule a visit to your home to install the visual smoke alarm and to conduct a free home fire safety audit?

Yes No

Name of applicant: _____

Signature: _____

Date: _____

PART B – PROOF OF ELIGIBILITY

To confirm you are eligible for a subsidised visual smoke alarm, you must provide proof of one of three eligibility options (please tick your preferred option and provide the necessary information and/or documentation)

OPTION 1: A recent audiogram from an audiology clinic (must be issued within the past twelve (12) months)

or

OPTION 2: A reference from an audiologist at Australian Hearing or a private audiologist, stating that you have a profound hearing loss. Please fill out the form below.

REFERENCE ON BEHALF OF APPLICANT

An Authorised Referee is to complete the following reference on behalf of the applicant complying with Option 3

I confirm that _____ is profoundly deaf and
(applicant's name)

meets the eligibility criteria for the Visual Smoke Alarm Subsidy Program.

Name of Authorised Referee:	
Organisation:	
Position/Role:	
Phone/TTY:	
Email:	
Authorised Referee Signature:	

PART C – APPLICANT DECLARATION & SUBMISSION OF FORM

APPLICANT DECLARATION

I _____ confirm the information I have provided is correct and that no other member of the household has applied for the subsidy.

Applicant's
Signature:

Date:

APPLICATION CHECKLIST

Before submitting this form to Tasdeaf, have you:

- Answered all questions?
- Provided the required references OR supplied information that proves your eligibility?
- Signed and dated this application?

SUBMITTING THE APPLICATION FORM

Please complete all sections of this form and post to:

Tasdeaf
Visual Smoke Alarm Subsidy Program
139 New Town Road
New Town TAS 7008

QUESTIONS? THE APPLICATION FORM

For any further information, please contact:

Tasdeaf
(03) 62281955
catherine.g@tasdeaf.org.au