



Visual Smoke Alarm Subsidy
Application Form - **PART A**

Please fill in **one** application form per **household**

CONTACT INFORMATION	
Name:	
Phone:	
Postal Address:	
Postcode:	
Fax:	
Mobile (SMS):	
Email:	

ELIGIBILITY QUESTIONS (please tick)	
Please note: You will need to make a \$50 co-payment for each alarm received.	
Are you profoundly deaf?	<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"/> Office of Housing accommodation (e.g. Public Housing) <input type="checkbox"/> Disability funded accommodation (e.g. A Community Residential Unit) <input type="checkbox"/> Other (please state): <hr/>
Which age group are you in?	<input type="checkbox"/> Under 18 <input type="checkbox"/> 18 - 24 <input type="checkbox"/> 25 - 44 <input type="checkbox"/> 45 - 64 <input type="checkbox"/> 65 +
If you are under 18, do you live independently?	<input type="checkbox"/> Yes <input type="checkbox"/> No

Which of the following do you use in every day communication?	<input type="checkbox"/> Auslan <input type="checkbox"/> Other Sign Language (please state): <hr/> <input type="checkbox"/> Spoken English <input type="checkbox"/> Spoken Language other than English <input type="checkbox"/> Other (please state): <hr/>
--	--

Please provide us with details of the occupants of your household

	Age	Hearing Loss	Method of Communication
Person 1	<input type="checkbox"/> Under 18 <input type="checkbox"/> 18 – 24 <input type="checkbox"/> 25 - 44 <input type="checkbox"/> 45 - 64 <input type="checkbox"/> 65 +	<input type="checkbox"/> Hearing <input type="checkbox"/> Mild Loss <input type="checkbox"/> Moderate Loss <input type="checkbox"/> Severe Loss <input type="checkbox"/> Profoundly Deaf	<input type="checkbox"/> Auslan <input type="checkbox"/> Other Sign Language <input type="checkbox"/> Spoken English <input type="checkbox"/> Spoken Language other than English <input type="checkbox"/> Other
Person 2			
Person 3			
Person 4			
Person 5			

To verify that you meet the eligibility criteria for this subsidy, please provide:	
<p>One (1) reference from a service, deaf club, support or social group that sees deaf people</p> <p style="text-align: center;">OR</p> <p>One (1) written reference from hearservice, Australian Hearing or private audiologist stating that you have a profound hearing loss or a recent (past 6 months) audiogram from an Audiology clinic.</p>	
Are you a Health Care Card Holder?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Which of the following best describes your living situation?	<input type="checkbox"/> Living alone <input type="checkbox"/> Living in a deaf household (a house without any hearing occupants) <input type="checkbox"/> Living in a hearing household (a house with at least one hearing occupant) <input type="checkbox"/> Other: _____

PART B

APPLICANT TO COMPLETE

I _____ confirm the information I have provided is correct.
(applicant name)

**Applicants
Signature:**

Date:

REFEREE TO COMPLETE - Please tick one of the following:

Reference from a service, deaf club, support or social group that sees deaf people	<input type="checkbox"/>
Reference from hearservice , Australian Hearing or private audiologist stating that you have a profound hearing loss or a recent (past 6 months) audiogram from an Audiology clinic.	<input type="checkbox"/>

STATEMENT BY AUTHORISED REFEREE

I confirm that _____ (applicant name) is profoundly deaf and meets the eligibility criteria for the Smoke Alarm Subsidy.

Name of Authorised Referee:

Organisation:

Position/Role:

Email:

TTY/Phone:

Authorised Referee Signature:

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?

Please return the completed form in the enclosed reply paid envelope.

For more information contact Tasdeaf on: Ph/TTY: 6228 1955 or SMS: 0418 341 373