M.A.T. APPLICATION—PART 1
MARYLAND ACCESSIBLE TELECOMMUNICATIONS
301 W. Preston Street, Suite 1008A, Baltimore, MD 21201
800-552-7724 (V/TTY) • www.mdrelay.org

Please print. Please use ink.

<table>
<thead>
<tr>
<th>Name:</th>
<th>First</th>
<th>MI</th>
<th>Last</th>
</tr>
</thead>
<tbody>
<tr>
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</tbody>
</table>

Mailing Address (must not be a PO Box): Apt.

<table>
<thead>
<tr>
<th>City</th>
<th>State</th>
<th>Zip Code</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
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</tbody>
</table>

Social Security Number Date of Birth: m d y y y

E-mail

Your County (check one):

- Allegany
- Anne Arundel
- Baltimore City
- Baltimore County
- Calvert
- Caroline
- Carroll
- Cecil
- Charles
- Dorchester
- Frederick
- Garrett
- Harford
- Howard
- Kent
- Montgomery
- Prince George's
- Queen Anne's
- Saint Mary's
- Somerset
- Talbot
- Washington
- Wicomico
- Worcester

Voice TTY VCO HCO Video

Circle all that apply

No phone? Can't use the phone? Who can we call?

<table>
<thead>
<tr>
<th>Name</th>
<th>Relationship</th>
<th>Phone number</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
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</tbody>
</table>

Under 18? Have a Guardian?

<table>
<thead>
<tr>
<th>Parent/Guardian Name</th>
<th>E-Mail</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Phone number

Voice TTY VCO HCO Video

Circle all that apply

Your means of communication—please check all that apply:

- Voice
- Read lips
- ASL
- Signed English
- Written notes
- TTY
- Braille

Applied before?

- No
- Yes—What year?

For additional applications, please visit www.mdrelay.org
Or, email: moreinfo@mdrelay.org
M.A.T. APPLICATION—PART 2
ELIGIBILITY

MARYLAND ACCESSIBLE TELECOMMUNICATIONS
301 W. Preston Street, Suite 1008A, Baltimore, MD 21201
800-552-7724 (V/TTY) • www.mdrelay.org

ARE YOU (if yes, put a check)

☐ more than 5 years old?
☐ a Maryland resident?
☐ someone who has trouble using a regular phone because of a disability?

DO YOU (if yes, put a check)

☐ have land line telephone service in your home now?
   If not, have you applied to get telephone service?  ☐ Yes  ☐ No

☐ Receive one of the following financial benefits:
  ☐ Social Security (SSA)
  ☐ SSI (Supplemental Security Income)
  ☐ SSDI (Social Security Disability Insurance)
  ☐ TANF (Temporary Assistance for Needy Families)
  ☐ TDAP (Temporary Disability Assistance Program)
  ☐ Pharmacy Assistance
  ☐ Veteran’s Benefits
  ☐ HUD housing assistance
  ☐ Medical Assistance
  ☐ Other state or federal benefits (please list):__________________________

If you receive any of these benefits—please send a COPY of paperwork as proof.
PLEASE DO NOT SEND ORIGINALS (they will not be returned)!

IF YOU DO NOT RECEIVE THESE BENEFITS BUT HAVE A LIMITED INCOME, WE WILL STILL CONSIDER YOU! PLEASE SEND US THE FOLLOWING:

☐ Copy of ONE of these: last 2 pay stubs, OR; unemployment pay stubs, OR; last year’s income tax forms

☐ Copy of your telephone bill (or other Utility Bill)

☐ Copy of your Photo ID, Driver’s license or Identification card

PLEASE DO NOT SEND ORIGINALS (they will not be returned)!

For additional applications, please visit www.mdrelay.org
Or, email: moreinfo@mdrelay.org
M.A.T. APPLICATION—PART 3
STATEMENT OF TERMS AND CONDITIONS
for Acceptance of State Property for Personal Use

I understand and agree to the following:

1. The telecommunications equipment is the property of the State of Maryland. The equipment is loaned to me for my personal use to access the telephone and I may use it for as long as I am a resident of this State. The conditions of my use are: (1) I will not sell, pawn, give away, loan it or otherwise transfer any rights I might have to this equipment to others and (2) I will comply with all of the terms and conditions of this statement which I voluntarily agree to sign.

2. I will protect the equipment from damage by liquid, extreme temperatures and poor care. I understand if the equipment is deliberately damaged, I may be required to pay for repairs.

3. If the equipment is damaged, I will NOT try to repair or disassemble equipment. I will return equipment to the vendor. I understand if I try to repair or disassemble equipment, it will void the manufacturer’s warranty and I will be required to pay for repairs on equipment.

4. When equipment repair is needed due to NORMAL WEAR & TEAR, it will be provided to me at no cost. I must send the equipment back to the vendor for service.

5. If my equipment is STOLEN, I will report it to the police immediately. I will send a copy of the police report to the MAT office immediately. I can not be issued a replacement until I have done this.

6. If I LOSE my specialized telephone equipment, I must report the loss to the State of Maryland/MAT office. I understand that the State will NOT give me another piece of equipment if lost.

7. I understand that it is against the law to file false statements regarding loss, damaged or stolen State property. I understand that false statements filed by me can result in my being criminally prosecuted. I understand that if I SELL or PAWN the equipment, I can be criminally prosecuted. I understand and agree to defend, indemnify, and hold harmless the State of Maryland, and its units, agents, agencies, departments, officials, representative and employees from any and all claims, damages and expenses of whatever nature arising out of use or misuse of equipment by me or any person of equipment given to me for my personal use. I further understand and agree that the State of Maryland, and its units, agents, agencies, departments, officials, representative and employees are not responsible for equipment furnished by the supplier of the equipment, for any acts of omissions of the supplier of the manufacturer of the equipment. Any claims or disputes over the equipment or maintenance of the equipment may be asserted solely against the supplier or the manufacturer of the equipment. The State shall not be considered a seller of the equipment and shall not be considered in any way a party to any transaction(s) between the customer and the supplier or manufacturer of the equipment.

8. Failure to comply with these Conditions of Acceptance may result in my being denied the privilege of having specialized telephone access equipment provided by the State of Maryland.

9. Upon approval of an application form, I understand I will be notified of acceptance in writing. If necessary, I will request training specific to the device I will receive. If I am a minor, a parent/guardian will accompany me to the required training to sign this statement. If I am physically unable to attend training, I can call 1-800-552-7724 to arrange for alternative site training.

Having read the above conditions or having had them read and explained to me, I agree to comply with all of the terms and conditions that I, or the minor for whom I am signing, is eligible to receive the requested equipment having (1) the required medical certification of disability; (2) met the income guidelines by currently receiving SSI, SSDI, TDAP or TANF; (3) signed the statement of terms and conditions for acceptance of State property; and (4) am not receiving similar equipment through other State or Federal agencies, or departments.

Print Name

Signature (Applicant or parent/guardian, if under 18 years old)  

Date

Witness

Date

Signature of Interpreter (if forms were interpreted)
M.A.T. APPLICATION—PART 4  
DISABILITY CERTIFICATION FORM

Applicant: Please complete this part and give the form to your doctor, audiologist, rehabilitation counselor or speech pathologist.

Applicant’s Name ___________________________ Date of Birth: m m / d d / y y y y
Address ___________________________ Apt.
City ___________________________ State ___________________________ Zip Code ___________________________
Social Security Number ___________________________ Phone Number ___________________________

I authorize TAM/MAT to have access to and use the information contained in this Disability Certification Form.

Applicant’s signature ___________________________ Date __________

PROFESSIONAL CERTIFICATION SECTION

Note to Health Care Provider: This form must be filled out by a practicing Maryland licensed physician, audiologist, rehabilitation counselor, or speech pathologist acting within the scope of his or her license or by an authorized representative of a Stage agency or educational institution approved by Telecommunications Access of Maryland.

I certify that the above named person has the impairment(s) marked below and is limited in his/her ability to use a regular phone.

Signature: ___________________________ Date: __________
Printed name: ___________________________

Check one: □ Physician □ Audiologist □ Rehabilitation Counselor □ Speech Language Pathologist
□ Other health care professional (specify) ___________________________

Office Address: ___________________________
City, State, Zip Code: ___________________________
Phone Number: ___________________________ MD State Lic/Cert # ___________________________

DISABILITY (check all that apply)

☐ Deaf/Deafened—severe to profound hearing loss; cannot benefit from telephone amplification

☐ Hard of Hearing—needs amplification to use effectively use a telephone. Hearing loss is:
□ mild □ moderate □ severe

☐ Low/Vision/Blind—vision with correction is 20/200 or less in the better eye or the visual field is
10 degrees or less

☐ Deafblind—severe to profound hearing loss and vision with correction of 20/200 or less in the better eye or the visual field is 10 degrees or less

☐ Speech Impaired—unable to speak intelligibly or requires amplification to be heard on the phone

☐ Mobility Impaired—☐ upper body □ lower body □ both—impaired ability to grip, lift, hold or
dial the telephone or impaired ability to get to the phone when it rings

☐ Cognitively Impaired—impaired ability to dial a series of numbers, to access (or memorize) a list of phone numbers or to use the phone to get emergency services.

Note to Health Care Provider—This form can be faxed directly to: 410-767-4276.
Or FOLD and MAIL to the address on the back.
Questions? Call Customer Service at 800-552-7724 (V/TTY)
Authorization for Release of Medical Information

Last 4 Digits of Social Security Number

Date of Birth

   ______   ______   ______
   Month    Day     Year

Name

First               Initial               Last

1. In accordance with Maryland’s Health General Article §4-303, I authorize the use or disclosure of the above-named individual’s health information as described below.

2. The following individuals or organizations are authorized to make the disclosures:

   Name of physician or health care professional completing Disability Certification Form:

3. The health information may be disclosed to and used by Telecommunications Access of Maryland, Department of Information Technology, 301 W Preston Street, Suite 1008A, Baltimore, MD 21201 and contracting organizations for the purpose of the application for and evaluation of Maryland Accessible Telecommunications equipment.

4. The type and amount of information to be used or disclosed is as follows:

   Confirmation of disability(s) related to any of the following:
   a. Hearing
   b. Vision
   c. Speech
   d. Mobility
   e. Cognition

5. I understand I may inspect or copy the information to be used or disclosed. I understand any disclosure of information carries with it the potential for an unauthorized re-disclosure and the information may not be protected by federal confidentiality rules.

6. This authorization shall expire one year after the date of its execution.

If I have questions about disclosure of my health information, I can contact Telecommunication Access of Maryland and speak with a representative.

Print Name

Signature (Applicant or parent/guardian, if under 18 years old)               Date

Witness Signature               Date

Signature of Interpreter (if forms were interpreted)               Date
Is DORS Right for Me?

If you have a disability or serious health condition that makes it hard for you to get or keep a job and you want to work, then DORS may be the choice for you.

Even though going to work is not easy, success is possible. The first step to deciding if you want DORS to help you get a job is getting information. We invite you to think about some questions that will help you to decide if DORS is right for you. It will only take a few minutes.

"I have a disability or serious health condition."
If your answer is "No," then DORS may not be right for you. DORS helps people with disabilities.

"My disability or serious health condition makes it hard for me to get or keep a job."
If your answer is "No," then DORS may not be right for you. To be eligible for DORS services, your disability or illness must impact your ability to work.

"I want a job."
If your answer is "No," then DORS may not be right for you. DORS helps people with disabilities who want to work. If working is not your goal, please contact your local Center for Independent Living for assistance.

"I need a job immediately."
If your answer is "Yes," then DORS may not be right for you. DORS is not an employment agency. DORS helps prepare people with disabilities to go to work or keep the job they have. This process can take many months. If you need a job immediately, your local One-Stop Career Center may be able to help.

"I have the time and interest to make a plan for getting a job."
If your answer is "No," then DORS may not be right for you. DORS assists people with disabilities in the process of preparing for and getting a job, but DORS can't do all the work. You have to be committed to the process and carry out the plan you create for employment.

"I am looking for someone to help me take care of my basic living needs (food, clothing and housing)."
If your answer is "Yes," then DORS may not be right for you. Unfortunately, DORS does not pay for rent, mortgages, monthly utilities, insurance or food. If you are looking for help with paying for the cost of basic living needs, please contact the United Way of Central Maryland.

If DORS is right for you and you're ready to begin services, fill out our online referral form to get started!
## DORS Locations

### Headquarters

<table>
<thead>
<tr>
<th>Office Name</th>
<th>DORS Headquarters</th>
</tr>
</thead>
<tbody>
<tr>
<td>Supervisor</td>
<td>Scott Dennis, DORS Director</td>
</tr>
<tr>
<td>Address</td>
<td>2301 Argonne Drive</td>
</tr>
<tr>
<td>City/State/Zip</td>
<td>Baltimore MD 21218</td>
</tr>
<tr>
<td>Phone</td>
<td>410-554-9442/888-554-0334</td>
</tr>
<tr>
<td>Fax</td>
<td>410-554-9412</td>
</tr>
<tr>
<td>TTY or VP</td>
<td>443-798-2840</td>
</tr>
<tr>
<td>Email</td>
<td><a href="mailto:dors@maryland.gov">dors@maryland.gov</a></td>
</tr>
<tr>
<td>Directions</td>
<td>To DORS Headquarters</td>
</tr>
</tbody>
</table>

### Business Relations

<table>
<thead>
<tr>
<th>Office Name</th>
<th>Business Relations</th>
</tr>
</thead>
<tbody>
<tr>
<td>Supervisor</td>
<td>Darlene F. Peregoy, Program Manager</td>
</tr>
<tr>
<td>Address</td>
<td>2301 Argonne Drive</td>
</tr>
<tr>
<td>City/State/Zip</td>
<td>Baltimore, MD, 21218</td>
</tr>
<tr>
<td>Phone</td>
<td>410-554-9408/888-554-0334</td>
</tr>
<tr>
<td>Fax</td>
<td>410-554-9412</td>
</tr>
<tr>
<td>TTY or VP</td>
<td>443-798-2840</td>
</tr>
<tr>
<td>Email</td>
<td><a href="mailto:darlene.peregoy@maryland.gov">darlene.peregoy@maryland.gov</a></td>
</tr>
<tr>
<td>Directions</td>
<td>To DORS Headquarters</td>
</tr>
</tbody>
</table>

### Administration & Fiscal Services

<table>
<thead>
<tr>
<th>Office Name</th>
<th>Administration &amp; Fiscal Services</th>
</tr>
</thead>
<tbody>
<tr>
<td>Supervisor</td>
<td>Scott Dennis, AFS Director</td>
</tr>
<tr>
<td>Address</td>
<td>2301 Argonne Drive</td>
</tr>
<tr>
<td>City/State/Zip</td>
<td>Baltimore MD 21218</td>
</tr>
<tr>
<td>Phone</td>
<td>410-554-9442/888-554-0334</td>
</tr>
<tr>
<td>Fax</td>
<td>410-554-9412</td>
</tr>
<tr>
<td>TTY or VP</td>
<td>443-798-2840</td>
</tr>
</tbody>
</table>
443-798-2840 VP
Email
dors@maryland.gov
Directions
To DORS Headquarters

Office Name
Client Assistance Program (CAP)
Supervisor
Tom Laverty, CAP Director
Address
2301 Argonne Drive
City/State/Zip
Baltimore, MD 21218
Phone
410-554-9361/800-638-6243
Fax
410-554-9362
TTY or VP
410-554-9360 TTY
Email
CAP.dors@maryland.gov
Directions
To CAP

Statewide Field Offices

Office Name
Office of Field Services HQ
Supervisor
Jody Boone, OFS Director
Address
2301 Argonne Drive
City/State/Zip
Baltimore MD 21218
Phone
410-554-9442/888-554-0334
Fax
410-554-9412
TTY or VP
443-798-2840 VP
Email
dors@maryland.gov
Directions
To Field Services Headquarters

Region 1: Western Maryland – Allegany, Carroll, Frederick, Garrett, Upper Montgomery and Washington Counties

Office Name
Regional Office
Supervisor
Sharon Plump, Regional Director
Address
16 W. Washington Street
Hagerstown MD 21740-5583
Phone
301-733-1341
Fax
301-733-4805
TTY or VP
301-200-8082 VP
Email
region1.dors@maryland.gov
Directions
To Western MD Regional Office

Office Name
Cumberland
Supervisor
Erin Shahan
Address
138 Baltimore Street, Suite 201
Cumberland MD 21502-2590
Phone
301-777-2119
Fax
301-777-2056
TTY or VP
301-777-2119 TTY
Email
allegany-garrett.dors@maryland.gov
Directions
To Cumberland Office

Office Name
Frederick
Supervisor
Elona Napoli
Address
1890 North Market Street, Suite 300
Frederick MD 21701
Phone
240-629-7581
Fax
240-629-7587
TTY or VP
301-200-8093 VP
Email
Frederick.dors@maryland.gov
Directions
To Frederick Office

Office Name
Germantown West
Supervisor
Steven Downs
<table>
<thead>
<tr>
<th>Office Name</th>
<th>Hagerstown</th>
<th>Supervisor</th>
<th>Erin Shahan</th>
</tr>
</thead>
<tbody>
<tr>
<td>Address</td>
<td>16 W. Washington Street</td>
<td></td>
<td></td>
</tr>
<tr>
<td>City/State/Zip</td>
<td>Hagerstown MD 21740-5583</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Phone</td>
<td>301-733-1209</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Fax</td>
<td>240-313-9243</td>
<td></td>
<td></td>
</tr>
<tr>
<td>TTY or VP</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Email</td>
<td><a href="mailto:Hagerstown.dors@maryland.gov">Hagerstown.dors@maryland.gov</a></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Directions</td>
<td>To Hagerstown Office</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Region 2: Southern Maryland & Lower Shore – Anne Arundel, Calvert, Caroline, Charles, Dorchester, Queen Anne’s, St. Mary’s, Somerset, Talbot, Wicomico & Worcester Counties

Office Name
https://dors.maryland.gov/resources/Pages/locations.aspx
Regional Office
Supervisor
Michelle Stewart, Regional Director
Address
2525 Riva Road, Suite 101
City/State/Zip
Annapolis MD 21401
Phone
410-974-7604
Fax
410-974-7747
TTY or VP
Email
region2.dors@maryland.gov
Directions
To Southern MD Regional Office

Office Name
Annapolis
Supervisor
Carmen Procida
Address
49 Old Solomons Island Road #202
City/State/Zip
Annapolis MD 21401
Phone
410-974-7608
Fax
410-974-7741
TTY or VP
410-415-9301 VP
Email
Annapolis.dors@maryland.gov
Directions
To Annapolis Office

Office Name
Easton
Supervisor
Jena Paquin, Regional Administrator
Address
8737 Brooks Drive, Suite 106
City/State/Zip
Easton MD 21601
Phone
410-770-4646
Fax
410-819-6840
TTY or VP
Email
Easton.dors@maryland.gov
Directions
To Easton Office

Office Name
Linthicum

https://dors.maryland.gov/resources/Pages/locations.aspx
DORS Locations

Supervisor
Caroline Baio
Address
613 Global Way
City/State/Zip
Linthicum Heights MD 21090
Phone
410-636-9010
Fax
410-636-9019
TTY or VP
Email
Linthicum.dors@maryland.gov
Directions
To Linthicum Heights Office

Office Name
Prince Frederick
Supervisor
Carmen Procida
Address
200 Duke Street, Suite 1000
City/State/Zip
Prince Frederick MD 20678-6303
Phone
410-535-2620
Fax
443-550-6890
TTY or VP
Email
PrinceFrederick.dors@maryland.gov
Directions
To Prince Frederick Office

Office Name
Salisbury
Supervisor
Anna Moorhead
Address
116 W. Main Street, Suite 403
City/State/Zip
Salisbury MD 21801
Phone
410-546-1580
Fax
410-546-8407
TTY or VP
410-415-9299 VP
Email
Salisbury.dors@maryland.gov
Directions
To Salisbury Office

Office Name
Tri-County - St. Mary's
Supervisor
Suzie Miller
Region 3: Baltimore City & Eastern Baltimore County

Office Name
Regional Office
Supervisor
Darlene Ginn, Regional Director
Address
1010 Park Avenue, Suite 110
City/State/Zip
Baltimore MD 21201
Phone
410-333-6119
Fax
410-244-5620
TTY or VP
410-333-5288
Email
region3.dors@maryland.gov
Directions
To Baltimore City Regional Office
Baltimore - Argonne Dr.
Supervisor
Vacant
Address
2301 Argonne Drive
City/State/Zip
Baltimore MD 21218
Phone
410-554-9488
Fax
410-261-2957
TTY or VP
Email
BaltimoreNEUnit35.dors@maryland.gov
Directions
To Baltimore Argonne Dr. Office

Office Name
Baltimore - Park Ave.
Supervisor
Pamela Clayton-Johnson
Address
1010 Park Avenue, Suite 102
City/State/Zip
Baltimore MD 21201
Phone
410-333-6117
Fax
410-244-5874
TTY or VP
410-333-5288 TTY
Email
ParkAveUnit37.dors@maryland.gov
Directions
To Baltimore Park Ave. Office

Office Name
Gaslight Square
Supervisor
Alice Crowder
Address
1401 Severn Street
City/State/Zip
Baltimore MD 21230
Phone
410-347-4130
Fax
410-783-8960
TTY or VP
410-415-9296 VP
Email
BaltimoreSUnit36.dors@maryland.gov
Directions
To Baltimore Gaslight Office

Office Name
Eastern Baltimore Co.
**Supervisor**
Trina Ball

**Address**
2301 Argonne Drive
City/State/Zip
Baltimore MD 21218

**Phone**
410-554-9506

**Fax**
410-554-3323

**TTY or VP**

**Email**
obo.dora@maryland.gov

**Directions**
To Eastern Baltimore County Office

---

**Region 5: Central Maryland & Upper Shore – Baltimore, Cecil, Harford, Howard and Kent Counties**

<table>
<thead>
<tr>
<th>Office Name</th>
<th>Regional Office</th>
<th>Supervisor</th>
</tr>
</thead>
<tbody>
<tr>
<td>Office Name</td>
<td>Regional Office</td>
<td>Matthew Jackson, Regional Director</td>
</tr>
</tbody>
</table>

**Address**
10461 Mill Run Circle, Suite LL1
City/State/Zip
Owings Mills MD 21117

**Phone**
410-998-2040

**Fax**
410-998-2063

**TTY or VP**
410-321-4035

**Email**
region5.dors@maryland.gov

**Directions**
To Central MD Regional Office

---

**Office Name**
Bel Air

**Supervisor**
Alyssa Donser

**Address**
2 South Bond Street, Suite 102
City/State/Zip
Bel Air MD 21014-3736

**Phone**
410-836-7636

**Fax**
410-836-4584

**TTY or VP**

**Email**
BelAir.dors@maryland.gov

**Directions**
To Bel Air Office
<table>
<thead>
<tr>
<th>Office Name</th>
<th>Columbia</th>
</tr>
</thead>
<tbody>
<tr>
<td>Supervisor</td>
<td>Vacant</td>
</tr>
<tr>
<td>Address</td>
<td>7161 Columbia Gateway Dr, Suite D</td>
</tr>
<tr>
<td>City/State/Zip</td>
<td>Columbia MD 21046</td>
</tr>
<tr>
<td>Phone</td>
<td>410-290-2640</td>
</tr>
<tr>
<td>Fax</td>
<td>410-290-2651</td>
</tr>
<tr>
<td>TTY or VP</td>
<td></td>
</tr>
<tr>
<td>Email</td>
<td><a href="mailto:Columbia.dors@maryland.gov">Columbia.dors@maryland.gov</a></td>
</tr>
<tr>
<td>Directions</td>
<td>To Columbia Office</td>
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<table>
<thead>
<tr>
<th>Office Name</th>
<th>Owings Mills</th>
</tr>
</thead>
<tbody>
<tr>
<td>Supervisor</td>
<td>Jessica Markum</td>
</tr>
<tr>
<td>Address</td>
<td>10461 Mill Run Circle, Suite LL1</td>
</tr>
<tr>
<td>City/State/Zip</td>
<td>Owings Mills MD 21117</td>
</tr>
<tr>
<td>Phone</td>
<td>410-998-2030</td>
</tr>
<tr>
<td>Fax</td>
<td>410-998-2075</td>
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<tr>
<td>TTY or VP</td>
<td></td>
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<tr>
<td>Email</td>
<td><a href="mailto:OwingsMills.dors@maryland.gov">OwingsMills.dors@maryland.gov</a></td>
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<table>
<thead>
<tr>
<th>Office Name</th>
<th>Towson</th>
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</thead>
<tbody>
<tr>
<td>Supervisor</td>
<td>Gloria Diggs-Branch</td>
</tr>
<tr>
<td>Address</td>
<td>300 E. Joppa Road, Suite 408</td>
</tr>
<tr>
<td>City/State/Zip</td>
<td>Towson MD 21286-5352</td>
</tr>
<tr>
<td>Phone</td>
<td>410-321-4044</td>
</tr>
<tr>
<td>Fax</td>
<td>410-321-4054</td>
</tr>
<tr>
<td>TTY or VP</td>
<td>410-415-9300 VP</td>
</tr>
<tr>
<td>Email</td>
<td><a href="mailto:Towson.dors@maryland.gov">Towson.dors@maryland.gov</a></td>
</tr>
<tr>
<td>Directions</td>
<td>To Towson Office</td>
</tr>
</tbody>
</table>
Office Name
Elkton
Supervisor
Alyssa Bonser
Address
103 Chesapeake Boulevard, Suite B
City/State/Zip
Elkton MD 21921-5945
Phone
410-996-0620
Fax
410-996-0626
TTY or VP
Email
Elkton.dors@maryland.gov
Directions
To Elkton Office

Region 6: D.C. Suburbs – Lower Montgomery and Prince George’s Counties

Office Name
Regional Office
Supervisor
Beth Lash, Regional Director
Address
4451-Z Parliament Place
City/State/Zip
Lanham MD 20706-1843
Phone
301-306-3600
Fax
301-306-1046
TTY or VP
301-200-8084 VP
Email
region6.dors@maryland.gov
Directions
To Washington Metro Regional Office

Office Name
Montgomery Transitioning Unit
Supervisor
Vacant
Address
20010 Century Boulevard, Suite 400
City/State/Zip
Germantown MD 20874
Phone
301-601-1500
Fax
301-540-7026
TTY or VP
301-200-8083 VP
Email
Directions
To Germantown Office

Office Name
Lanham
Supervisor
Patricia Simon
Address
4451-Z Parliament Place
City/State/Zip
Lanham MD 20706-1843
Phone
301-306-3600
Fax
301-306-3636
TTY or VP
301-200-8084 VP
Email
Lanham.dors@maryland.gov
Directions
To Lanham Office

To Suitland Office

Office Name
Suitland
Supervisor
Natalie Mitchell
Address
5001 Silver Hill Road #306
City/State/Zip
Suitland MD 20746
Phone
301-967-7257
Fax
301-967-7263
TTY or VP
Email
Suitland.dors@maryland.gov
Directions
To Suitland Office

To Wheaton Office

Office Name
Wheaton
Supervisor
Address
11002 Veirs Mill Road #60b
City/State/Zip
Wheaton MD 20902-1991
Phone
301-949-3750
Fax
301-949-5876
TTY or VP
301-200-8090 VP
Email
Wheaton.dors@maryland.gov
Directions
To Wheaton Office
# Office for Blindness & Vision Services

<table>
<thead>
<tr>
<th>Office Name</th>
<th>Office for Blindness &amp; Vision Services</th>
</tr>
</thead>
<tbody>
<tr>
<td>Supervisor</td>
<td>Toni March, OBVS Director</td>
</tr>
<tr>
<td>Address</td>
<td>2301 Argonne Drive</td>
</tr>
<tr>
<td>City/State/Zip</td>
<td>Baltimore, MD 21218</td>
</tr>
<tr>
<td>Phone</td>
<td>410-554-9277/666-614-4780</td>
</tr>
<tr>
<td>Fax</td>
<td>410-554-9197</td>
</tr>
<tr>
<td>TTY or VP</td>
<td>410-415-9317 VP</td>
</tr>
<tr>
<td>Email</td>
<td><a href="mailto:obvs.dors@maryland.gov">obvs.dors@maryland.gov</a></td>
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<th>Office Name</th>
<th>Southern MD &amp; Eastern Shore</th>
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<tbody>
<tr>
<td>Supervisor</td>
<td>Amy Blandford</td>
</tr>
<tr>
<td>Address</td>
<td>2525 Riva Road, Suite 101</td>
</tr>
<tr>
<td>City/State/Zip</td>
<td>Annapolis, MD 21401</td>
</tr>
<tr>
<td>Phone</td>
<td>410-979-7604</td>
</tr>
<tr>
<td>Fax</td>
<td>410-974-7747</td>
</tr>
<tr>
<td>TTY or VP</td>
<td>301-645-8883 TTY</td>
</tr>
<tr>
<td>Email</td>
<td><a href="mailto:obvs.dors@maryland.gov">obvs.dors@maryland.gov</a></td>
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<tr>
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<tbody>
<tr>
<td>Supervisor</td>
<td>Roxanne Rattray-Simmonds</td>
</tr>
<tr>
<td>Address</td>
<td>2301 Argonne Drive</td>
</tr>
<tr>
<td>City/State/Zip</td>
<td>Baltimore, MD 21218</td>
</tr>
<tr>
<td>Phone</td>
<td>410-554-9217</td>
</tr>
<tr>
<td>Fax</td>
<td>410-554-5407</td>
</tr>
<tr>
<td>TTY or VP</td>
<td></td>
</tr>
<tr>
<td>Email</td>
<td><a href="mailto:obvs.dors@maryland.gov">obvs.dors@maryland.gov</a></td>
</tr>
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</table>
Western MD & Montgomery Co.
Supervisor
Elo Enoch
Address
11002 Veirs Mill Road, Suite 305
City/State/Zip
Wheaton MD 20902
Phone
301-949-3750
Fax
301-949-5876
TTY or VP
866-338-7985 VP
Email
obvs.dors@maryland.gov

Workforce & Technology Center

Office Name
Workforce & Technology Center
Supervisor
Jean Jackson, WTC Director
Address
2301 Argonne Drive
City/State/Zip
Baltimore MD 21218
Phone
410-554-9100/888-200-7117
Fax
410-554-9386
TTY or VP
443-842-6138 VP
Email
wtc.dors@maryland.gov
Directions
To WTC

Office Name
Academic Services
Supervisor
Melissa Hults-Mokros
Address
2301 Argonne Drive
City/State/Zip
Baltimore MD 21218
Phone
410-554-9323
Fax
410-554-9131
TTY or VP
443-842-6138 VP
Email
melissa.hults-mokros@maryland.gov
Directions
To WTC
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<tr>
<th>Office Name</th>
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<tr>
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<td>Leo Yates</td>
</tr>
<tr>
<td>Address</td>
<td>2301 Argonne Drive</td>
</tr>
<tr>
<td>City/State/Zip</td>
<td>Baltimore MD 21218</td>
</tr>
<tr>
<td>Phone</td>
<td>410-554-9335</td>
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<tr>
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</tr>
<tr>
<td>TTY or VP</td>
<td>443-842-6138 VP</td>
</tr>
<tr>
<td>Email</td>
<td><a href="mailto:leo.yates@maryland.gov">leo.yates@maryland.gov</a></td>
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<tbody>
<tr>
<td>Supervisor</td>
<td>Trina Robinson</td>
</tr>
<tr>
<td>Address</td>
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</tr>
<tr>
<td>City/State/Zip</td>
<td>Baltimore MD 21218</td>
</tr>
<tr>
<td>Phone</td>
<td>410-554-9159</td>
</tr>
<tr>
<td>Fax</td>
<td>410-554-9174</td>
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<tr>
<td>TTY or VP</td>
<td>443-842-6138 VP</td>
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<tr>
<td>Email</td>
<td><a href="mailto:trina.robinson@maryland.gov">trina.robinson@maryland.gov</a></td>
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</table>
Office Name
Career & Technology Training
Supervisor
Melissa Hults-Mokros
Address
2301 Argonne Drive
City/State/Zip
Baltimore MD 21218
Phone
410-554-9323
Fax
410-554-9131
TTY or VP
443-842-6138 VP
Email
melissa.holts-mokros@maryland.gov
Directions
To WTC

Office Name
Center Counseling
Supervisor
Laura Wellmann
Address
2301 Argonne Drive
City/State/Zip
Baltimore MD 21218
Phone
410-554-9403
Fax
410-554-9131
TTY or VP
443-842-6138 VP
Email
laura.wellmann@maryland.gov
Directions
To WTC

Office Name
Center Records
Supervisor
Marcy Roberts
Address
2301 Argonne Drive
City/State/Zip
Baltimore MD 21218
Phone
410-554-9193
Fax
410-554-9339
TTY or VP
443-842-6138 VP
Email
marcy.roberts@maryland.gov
Directions
To WTC
### Office Name
Comprehensive Outpatient Rehabilitation
### Supervisor
Dr. Maya Desai
### Address
2301 Argonne Drive
City/State/Zip
Baltimore MD 21218
### Phone
410-554-9324
### Fax
410-554-9339
### TTY or VP
443-842-6138 VP
### Email
maya.desai@maryland.gov
### Directions
To WTC

### Office Name
Deaf & Hard of Hearing Services
### Supervisor
Penelope Shook
### Address
2301 Argonne Drive
City/State/Zip
Baltimore MD 21218
### Phone
410-554-9124
### Fax
410-554-9131
### TTY or VP
443-842-6138 VP
### Email
penelope.shook@maryland.gov
### Directions
To WTC

### Office Name
Employment Services
### Supervisor
Jessica Hawes
### Address
2301 Argonne Drive
City/State/Zip
Baltimore MD 21218
### Phone
410-554-9127
### Fax
410-554-9131
### TTY or VP
443-842-6138 VP
### Email
jessica.hawes@maryland.gov
### Directions
To WTC
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<tr>
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<td>Darice Bunch</td>
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<tr>
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<tr>
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<td>Baltimore MD 21218</td>
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<tr>
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<td>Email</td>
<td><a href="mailto:darice.bunch@maryland.gov">darice.bunch@maryland.gov</a></td>
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<tr>
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<tr>
<td>City/State/Zip</td>
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<tr>
<td>Email</td>
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<td>Dr. Maya Desai</td>
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<tr>
<td>Address</td>
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<td>Office Name</td>
<td>RTS Technology Services (RTS)</td>
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<tr>
<td>Supervisor</td>
<td>Brenda Isehnock</td>
</tr>
<tr>
<td>Address</td>
<td>2301 Argonne Drive</td>
</tr>
<tr>
<td>City/State/Zip</td>
<td>Baltimore MD 21218</td>
</tr>
<tr>
<td>Phone</td>
<td>410-554-9466</td>
</tr>
<tr>
<td>Fax</td>
<td>410-554-9222</td>
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<td>TTY or VP</td>
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<tr>
<td>Email</td>
<td><a href="mailto:brenda.isennock@maryland.gov">brenda.isennock@maryland.gov</a></td>
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<tbody>
<tr>
<td>Supervisor</td>
<td>Melissa Day</td>
</tr>
<tr>
<td>Address</td>
<td>2301 Argonne Drive</td>
</tr>
<tr>
<td>City/State/Zip</td>
<td>Baltimore MD 21218</td>
</tr>
<tr>
<td>Phone</td>
<td>410-554-9149</td>
</tr>
<tr>
<td>Fax</td>
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<td>TTY or VP</td>
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<td>Email</td>
<td><a href="mailto:melissa.day@maryland.gov">melissa.day@maryland.gov</a></td>
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<th>RTS Autism Services</th>
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<tbody>
<tr>
<td>Supervisor</td>
<td>Lee Armstrong</td>
</tr>
<tr>
<td>Address</td>
<td>2301 Argonne Drive</td>
</tr>
<tr>
<td>City/State/Zip</td>
<td>Baltimore MD 21218</td>
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<tr>
<td>Phone</td>
<td>410-554-9173</td>
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<td>Fax</td>
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<td>TTY or VP</td>
<td>443-842-6138 VP</td>
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<tr>
<td>Email</td>
<td><a href="mailto:lee.armstrong@maryland.gov">lee.armstrong@maryland.gov</a></td>
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</table>
Office Name
RTS Blind Services @ WTC
Supervisor
Kelly Blake
Address
2301 Argonne Drive
City/State/Zip
Baltimore MD 21218
Phone
410-554-9177
Fax
410-554-9222
TTY or VP
443-842-6138 VP
Email
kelly.blake@maryland.gov
Directions
To WTC

Office Name
RTS Driving
Supervisor
Pam Post
Address
2301 Argonne Drive
City/State/Zip
Baltimore MD 21218
Phone
410-554-9223
Fax
410-554-9576
TTY or VP
443-842-6138 VP
Email
pamj.post@maryland.gov
Directions
To WTC

Office Name
RTS Modifications
Supervisor
Pam Post
Address
2301 Argonne Drive
City/State/Zip
Baltimore MD 21218
Phone
410-554-9223
Fax
410-554-9468
TTY or VP
443-842-6138 VP
Email
pamj.post@maryland.gov
Directions
To WTC

https://dors.maryland.gov/resources/Pages/locations.aspx
Office Name
RTS Worksite Services
Supervisor
Wanda Oakman
Address
2301 Argonne Drive
City/State/Zip
Baltimore MD 21218
Phone
410-554-9351
Fax
410-554-9222
TTY or VP
443-842-6138 VP
Email
wanda.oakman@maryland.gov
Directions
To WTC

Office Name
RTS Computer Skills Training
Supervisor
Wanda Oakman
Address
2301 Argonne Drive
City/State/Zip
Baltimore MD 21218
Phone
410-554-9351
Fax
410-554-9222
TTY or VP
443-842-6138 VP
Email
wanda.oakman@maryland.gov
Directions
To WTC

Office Name
Residential Services
Supervisor
Darice Bunch
Address
2301 Argonne Drive
City/State/Zip
Baltimore MD 21218
Phone
410-554-9256
Fax
410-554-9368
TTY or VP
443-842-6138 VP
Email
darice.bunch@maryland.gov
Directions
To WTC
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<tr>
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<th>Work Readiness Programs</th>
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<tbody>
<tr>
<td>Supervisor</td>
<td>Robin Griffin</td>
</tr>
<tr>
<td>Address</td>
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</tr>
<tr>
<td>City/State/Zip</td>
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<td>Phone</td>
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<td>TTY or VP</td>
<td>443-842-6138 VP</td>
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<td>Email</td>
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<tr>
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<th>Workforce Services</th>
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<tbody>
<tr>
<td>Supervisor</td>
<td>James Evans</td>
</tr>
<tr>
<td>Address</td>
<td>2301 Argonne Drive</td>
</tr>
<tr>
<td>City/State/Zip</td>
<td>Baltimore MD 21218</td>
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<tr>
<td>Phone</td>
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<tr>
<td>TTY or VP</td>
<td>443-842-6138 VP</td>
</tr>
<tr>
<td>Email</td>
<td><a href="mailto:james.evans@maryland.gov">james.evans@maryland.gov</a></td>
</tr>
</tbody>
</table>
Disability Determination Services

Office Name
Disability Determination Services
Supervisor
Dayle Smith, DSS Director
Address
PO Box 1810
City/State/Zip
Cockeysville, MD 21030-1810
Phone
410-308-4500/800-492-4283
Fax
410-308-4400
TTY or VP
410-308-4550
Email
md.dd.timonium.dds@ssa.gov
Maryland State Department of Education  
Division of Rehabilitation Services  
www.dors.maryland.gov  
APPLICATION for REHABILITATION SERVICES

Referral Information
Social Security Number: ___________________________ Birth Date: ___________________________
Name (Last, First, Middle): ___________________________
What do you prefer to be called? ___________________________
Please list any previous last names (e.g. maiden name, etc.): _______________________________________
Who referred you to DORS? ___________________________

Home Address (house number and street address, apt., etc.): _______________________________________
City: ___________________________ State: ___________ Zip Code: ___________
County: ___________________________
Mailing Address: (if different from home address) _________________________________________________
City: ___________________________ State: ___________ Zip Code: ___________
County: ___________________________
Phone: ___________________________ ☐ Home ☐ Cell Phone ☐ Fax ☐ TDD ☐ Videophone ☐ Work
Second Phone: ___________________________ ☐ Home ☐ Cell Phone ☐ Fax ☐ TDD ☐ Videophone ☐ Work
Email Address: ___________________________

What is your living arrangement, and who do you live with at this time? _______________________________________

Emergency or Other Contacts:
Name: ___________________________ Relationship: ___________________________
Phone/TDD: ___________________________ Email: ___________________________
Name: ___________________________ Relationship: ___________________________
Phone/TDD: ___________________________ Email: ___________________________

Characteristics
Gender: ☐ Male ☐ Female ☐ I do not wish to self-identify
Please identify your race/ethnicity (check all that apply): ☐ American Indian or Alaskan Native ☐ Asian ☐ Black
☐ Native Hawaiian or Other Pacific Islander ☐ White
Are you Hispanic or Latino? ☐ Yes ☐ No

Do you need assistance with communicating in English? ☐ Yes ☐ No
Please explain: _______________________________________

Do you need assistance with reading English? ☐ Yes ☐ No
Please explain: _______________________________________

What is your primary language? ☐ English ☐ Chinese ☐ Korean ☐ Russian ☐ Spanish ☐ Vietnamese
☐ American Sign Language (ASL) ☐ Contact Signing/PSE ☐ Signed Exact English ☐ Foreign Sign Language
☐ Speech Reading ☐ Tactile Communication ☐ Other: _______________________________________

How would you prefer to receive written communication? ☐ Standard Print ☐ Braille ☐ Large Print ☐ Electronic Format/E-mail ☐ Audio Recording

If you would like DORS staff to send job leads, appointment reminders, schedule changes and other updates to you by text message, please indicate your cell phone number and cell phone service provider/carrier:
Cell Phone Number: ___________________________
Provider: ☐ AT&T ☐ Alltel ☐ Boost Mobile ☐ Cricket ☐ Metro PCS ☐ Net10 ☐ Sprint PCS ☐ Straight Talk
☐ T-Mobile ☐ TracFone ☐ US Cellular ☐ Verizon ☐ Virgin Mobile ☐ Other: ___________________________

Are you a U.S. Citizen? ☐ Yes ☐ No
If not, are you authorized to work in the U.S.? ☐ Yes ☐ No
Employers by law must require all new hires to fill out a federal I-9 "Employment Eligibility Verification" form based on certain forms of I.D. Which of the following forms of I.D. do you currently possess for I-9 verification? Please check all that apply: □ U.S. Passport □ Driver’s License □ State/Government-issued ID Card □ U.S. Military ID □ Permanent Resident Card ("Green Card") – Alien Registration Number: ___________________ Expiration: _______ □ Social Security Card □ Birth Certificate □ None
If you have no I.D., have you applied for I.D.? □ Yes □ No

Veteran Status
□ I do not wish to disclose. □ I am not a veteran.
□ Honorable discharge: Up to 180 days of active duty □ Honorable discharge: More than 180 days of active duty
□ General discharge: Up to 180 days of active duty □ General discharge: More than 180 days of active duty
□ Spouse of a veteran – If spouse of a veteran, what is the veteran's status (e.g., died, MIA, POW, Service Connected Disability, other)?

Please indicate below any programs or services with which you are involved at this time:
□ Adult Education and Literacy Program □ Employer-funded services
□ Behavioral Health Administration (BHA) □ Federal Student Aid Program
□ Center for Independent Living □ Mental Health Provider
□ Child Protective Services □ One-stop Employment/Training Center
□ Community Rehabilitation Program □ Other VR State Agency (Out-of-State)
□ Department of Labor, Licensing, & Regulation (DLLR) □ Public Housing Authority
□ Department of Social Services (DSS) □ Social Security Administration (e.g. Disability Determination Services or local office)
□ Developmental Disabilities Administration (DDA) □ Veterans Benefits Administration
□ Disability Organization or Advocacy Group □ Veterans Health Administration
□ Mental Hygiene Administration (MHA) □ Workers Compensation
□ Maryland Department of Disabilities (MDOD) □ Other Source: ____________________________
□ Educational Institution (high school or post-secondary) □ Social Security Ticket-to-Work Program: ____________________________

Employment Network through Social Security Ticket-to-Work Program:

Financial Information
How many dependents do you have, including yourself? ______
What is your gross monthly family income? $ ____________________

What is your primary source of support?
□ Personal Income (employment earnings, interest, dividends, rent, retirement including Social Security retirement)
□ Public Support (SSI, SSDI, Other Disability, TANF, VA, General Assistance, Worker’s Compensation, etc.)
□ Spouse, Family and Friends
□ Other Sources (private disability insurance and private charities)

Please identify your SSDI (Social Security Disability Insurance) Status:
□ Allowed/Receiving Benefits □ Denied Benefits □ Application Pending □ Benefits Discontinued/Terminated
□ Not an Applicant □ Status Not Known

Please identify your SSI (Supplemental Security Insurance) Status:
□ Allowed/Receiving Benefits □ Denied Benefits □ Application Pending □ Benefits Discontinued/Terminated
□ Not an Applicant □ Status Not Known

Please list all benefit amounts (per month):
SSI Type: □ Aged □ Blind □ Disabled $ __________ SSDI: $ __________
VA (Veterans Benefits): $ __________ TANF (Dept. Social Services): $ __________
General Assistance (Dept. Social Services): $ __________ Other Disability: $ __________
Workers’ Compensation: $ __________ Other: $ __________

If you receive TANF, how many total months in your lifetime have you received this benefit?

What medical insurance do you have? (check all that apply)
□ None □ Medicaid/Medicaid Assistance □ Medicare □ Workers’ Compensation □ Affordable Care Act
□ Exchange (State or Federal) □ Other Public Insurance – Source: ____________________________
□ I am employed and have private insurance through my own job.
☐ I am employed, and will have private insurance through the job I am doing now after a set period of time.
☐ I have private insurance through other means (parent or other family member).
If you have insurance, who is the policy holder? 

Medicaid Number: ____________________________ Medicare Number: ____________________________
Primary Adult Care (PAC) Number: ____________________________ Worker’s Compensation Claim Number: ____________________________

Education Information & History
If you are currently in high school:
What is your 10-digit Maryland State Student I.D.? ____________________________
What grade are you in? _______ What school do you attend? ____________________________
What year did you begin high school? _______ What year will you graduate or exit school? _______
When you graduate or exit school, do you expect to receive ☐ a diploma or ☐ a certificate? _______
Are you receiving education services and support under a 504 Accommodation Plan? ☐ Yes ☐ No
If not, are you receiving education services under an Individualized Education Plan (IEP)? ☐ Yes ☐ No

If you are not currently in high school:
Did you receive education services under an Individualized Education Plan (IEP) during your last year of high school? ☐ Yes ☐ No
If yes, did you graduate or exit school with a diploma or a certificate? ☐ Diploma ☐ Certificate ☐ Neither

What is the highest level of education you completed?
☐ No formal schooling ☐ AA Degree
☐ Grades 1-8 ☐ Bachelor’s Degree
☐ Grades 9-12 (no diploma) ☐ Master’s Degree
☐ Certificate of Completion ☐ Higher than a Master’s Degree
☐ High School Diploma or GED ☐ Credential after Bachelor’s Degree
☐ Post-Secondary Education (no degree or certificate) ☐ Credential after Master’s Degree
☐ Vocational/Technical Certificate

Are you currently a student, an intern, in training or volunteering? ☐ Yes ☐ No
If applicable, describe previous or current training/education: ____________________________

Employment Information
If you are not employed, when was the last date you were employed? ___________
If you are employed:
What is your job title? ____________________________
Is this self-employment or a Business Enterprise Program (BEP)? ☐ Self-Employment ☐ BEP ☐ No
How many hours do you work per week? ___________
What is your salary or hourly wage? $ _______
☐ annual ☐ monthly ☐ weekly ☐ hourly
Are you a transitioning service member? ☐ Yes ☐ No
Are you requesting services to help you maintain your employment? ☐ Yes ☐ No
Have you received a termination notice or a Worker Adjustment & Restraining Notification (WARN)
☐ Yes ☐ No

Work History - Please list your full work history, and start with most recent job first, or provide copy of your resume:
Employer: ____________________________ Start Date: ____________ End Date: ____________
Address: ____________________________ Job Duties: __________________________________________

Average Hours Worked Per Week: ____________ Salary: ____________________________
Reason for Leaving: ____________________________

Employer: ____________________________ Start Date: ____________ End Date: ____________
Address: ____________________________ Job Duties: ____________________________

Average Hours Worked Per Week: ____________ Salary: ____________________________
Reason for Leaving: ____________________________

Employer: ____________________________ Start Date: ____________ End Date: ____________
Address: ____________________________ Job Duties: ____________________________

Average Hours Worked Per Week: ____________ Salary: ____________________________
Reason for Leaving: ____________________________

Employer: ____________________________ Start Date: ____________ End Date: ____________
Address: ____________________________ Job Duties: ____________________________

MSDE-DORS-RS-1c: 6/16

DORS Application for Rehabilitation Services

Page 3 of 5

To obtain this Application in Braille, in large print, on disk or in other format, see your DORS counselor or call 1-888-554-0334.
Job Title: ____________________________ Job Duties: ____________________________

Average Hours Worked Per Week: ____________________________ Salary: ____________________________
Reason for Leaving: ____________________________
Please attach any additional work history.

**Disability Information** – Please list and describe your disabilities, beginning with your primary disability:

1. **Disability:** ____________________________ Date of onset: ____________________________
   - This disability is a result of: ____________________________
   - How does this disability limit your ability to obtain employment, work, or live independently?
     ____________________________

2. **Disability:** ____________________________ Date of onset: ____________________________
   - This disability is a result of: ____________________________
   - How does this disability limit your ability to obtain employment, work, or live independently?
     ____________________________

3. **Disability:** ____________________________ Date of onset: ____________________________
   - This disability is a result of: ____________________________
   - How does this disability limit your ability to obtain employment, work, or live independently?
     ____________________________

**Other Information**
Please describe any special needs or work-related concerns you may have (e.g., personal care assistance, child care, transportation, criminal background): ____________________________

______________________________________________________________

What do you hope to gain from participating in rehabilitation services (i.e., the kind of work you want to do or your independent living goals)?

______________________________________________________________

______________________________________________________________

______________________________________________________________

Other comments, concerns or additional information:

______________________________________________________________

______________________________________________________________

______________________________________________________________

**REQUEST FOR SERVICES AND NOTIFICATION OF RIGHTS**
I am requesting rehabilitation services and have been given a copy of the Opening Doors to Employment, Informed Choice and Client Assistance Program brochures. I understand my rights and responsibilities under this program. Information that I have provided is to the best of my knowledge true, correct and complete. I understand that giving DORS untrue and/or fraudulent information may result in services not being provided or continued. By signing this request I give permission for DORS to verify my status as a recipient of Social Security Disability Insurance (SSDI) and/or Supplemental Security Income (SSI).

Before signing, please discuss with your DORS counselor any information you do not understand.

Applicant Signature/Date: ____________________________

Signature of Parent or Representative: ____________________________
(if under age 18 or legal guardianship)
INFORMATION GATHERING

- The principal purposes served by gathering information requested on the Application, Financial Statement and individualized plan of services are 1) to determine your eligibility for rehabilitation services; 2) to determine what, if any financial participation you may be expected to provide; and 3) to plan your services.
- Refusal to provide the requested information will result in DORS finding you not eligible for services.
- You have a right to review, amend or correct the requested information under Maryland Annotated Code, State Government Article, Section 10-611-10-629.
- The requested information is not available for public inspection, unless you give written permission.
- The requested information is routinely shared with other governmental agencies when information is needed for you to obtain benefits or services; for audit, evaluation or research purposes connected with the administration of the rehabilitation program as long as confidentiality is safeguarded; and to obtain payment for services which have been provided when covered by third party resources.
- DORS requests the Social Security Number of applicants for services and uses it only for federal reporting purposes and, as applicable: (1) confirmation of Social Security benefits and presumption of eligibility, and (2) financial transactions.
Maryland State Department of Education
Division of Rehabilitation Services
Supported Employment Certification

This form may be used to confirm availability of funding for extended supported employment services prior to the expenditure of DORS supported employment funds for time-limited services. (NOTE: (1) This form is not required for consumers eligible for MHA-funded supported employment at either Evidence-Based Practice (EBP) programs or non-EBP programs; (2) The DDA Award letter or a copy of the DDA Provider Consumer Information System II (PCIS II) eligibility screen shall be accepted in lieu of this form.)

Forward Notification to:
DORS
Address:

DORS Counselor: ___________________________ Email: ___________________________
Phone: ___________________________ Fax (if faxed or emailed, please forward original copy also):

Client Name: ___________________________ Participant ID: ___________________________
Address: ___________________________

COMMITMENT OF RESOURCES FOR EXTENDED SERVICES
Authorization is required by Developmental Disabilities Administration (DDA) or an alternate source. Alternate sources will be considered on an individual basis.

To be completed by the authorized program/agency representative:
☐ A commitment of resources, subject to continued availability of funding, has been made for extended services at the completion of DORS services identified in the Individualized Plan for Employment (IPE).

☐ The source of extended services cannot be identified at this time; however, there is a reasonable expectation that a source will become available. The basis for expecting a funding commitment and anticipated time frame is as follows: ___________________________

☐ An alternate source of funding or provision of extended services has been identified, as follows: ___________________________

Extended services may include a variety of supports needed for the individual to achieve and maintain stability. Extended services require at least two job site visits per month to monitor job stability unless off-site monitoring is specified in the IPE. In instances of off-site monitoring, extended services involve two meetings with the individual per month.

Authorized Program/Agency Representative or Alternate Source:

Name: ___________________________ Signature: ___________________________
Title: ___________________________ Date: ___________________________
Program/Agency: ___________________________

For DORS ABI Program, Supervisor indicates extended funding approval in a case note.

c: DORS (original); Authorized Program/Agency Representative or Alternate Source
MSDE-DORS-RS-8e:02/14 Supported Employment Certification

To obtain this form in Braille, in large print, on disk or in other format, see DORS staff or call 1-888-554-0334.
Maryland State Department of Education
Division of Rehabilitation Services

Voter Registration Certification

The Division of Rehabilitation Services is an agency designated to offer the opportunity to apply to register to vote in Maryland. Please answer the following questions and sign the bottom.

Note: Applying to register or declining to register to vote will not affect the amount of assistance that you will be provided by this agency.

If you are not registered to vote where you live now, would you like to apply to register to vote here today?

[ ] Yes   [ ] No   [ ] Already registered   [ ] Took form home
[ ] Not eligible to register:
[ ] Under age 18
[ ] Not a U.S. citizen
[ ] Not a Maryland resident – refer to state of residence to register
[ ] History of felony conviction – refer to Maryland Board of Elections regarding restoration of voting rights

If you do not check any box, you will be considered to have decided not to register to vote at this time.

If you would like help in filling out the registration application form, we will help you. The decision whether to seek or accept help is yours. You may fill out the application form in private.

If you believe someone has interfered with your right to register or to decline to register to vote, your right to privacy in deciding whether to register or in applying to register to vote, or your right to choose your own political party or other political preference, you may file a written complaint with:

Maryland State Board of Elections
P.O. Box 6486
Annapolis, MD 21401-0486

Or call 1-800-222-VOTE

Signature: ____________________________

Participant ID: ____________________________
DORS needs information about your disability/disabilities to see if you are eligible for our program and what services you will need to get and keep a job or become more independent. DORS staff will keep this information confidential according to federal and state law.

What is your disability?

<p>| | | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>a.</td>
<td>Have you ever had a physical, mental or other problem which kept you from working or being independent?</td>
<td>Yes</td>
</tr>
<tr>
<td>b.</td>
<td>Are you currently under the care of a doctor, psychologist or therapist? (Please list on the back or at the end of this form.)</td>
<td>Yes</td>
</tr>
<tr>
<td>c.</td>
<td>Do you currently require the use of prescription medications? What are they and for what condition?</td>
<td>Yes</td>
</tr>
<tr>
<td>d.</td>
<td>Do you use or need some kind of assistive device or accommodation to help you function independently (eye glasses, hearing aid, braces, wheelchair, artificial limb or similar device)? What are they?</td>
<td>Yes</td>
</tr>
<tr>
<td>e.</td>
<td>Have you ever had a head injury or lost consciousness?</td>
<td>Yes</td>
</tr>
<tr>
<td>f.</td>
<td>Do you have a diagnosis or medical history of substance abuse or alcohol abuse?</td>
<td>Yes</td>
</tr>
<tr>
<td>g.</td>
<td>Are you HIV positive or do you have AIDS?</td>
<td>Yes</td>
</tr>
<tr>
<td>h.</td>
<td>Do you need assistance with routine activities of daily living (dressing, personal hygiene, meal preparation, household chores)?</td>
<td>Yes</td>
</tr>
<tr>
<td>i.</td>
<td>Do you have difficulty with such things as remembering, following instructions, doing what others expect of you?</td>
<td>Yes</td>
</tr>
<tr>
<td>j.</td>
<td>Do you have difficulty reading or understanding?</td>
<td>Yes</td>
</tr>
<tr>
<td>k.</td>
<td>Have you been told you have a “learning disability”?</td>
<td>Yes</td>
</tr>
<tr>
<td>l.</td>
<td>Have you had special education services?</td>
<td>Yes</td>
</tr>
<tr>
<td>m.</td>
<td>Do you have other health problems affecting your ability to work which are not listed here?</td>
<td>Yes</td>
</tr>
</tbody>
</table>
How does your disability make it difficult for you to work, get the job you want, or be independent?

What accommodations (devices or assistance) do you need in a school or work setting?

**MEDICAL INFORMATION**

Please complete the following about your current health care providers:

Family Doctor/HMO: ____________________________
Address: _____________________________________
Phone: ____________________________ Date Last Seen: __________
Current Treatment/Medications: ____________________________
   Side Effects: ____________________________

Specialist's Name: ____________________________ Specialty: __________
Address: _____________________________________
Phone: ____________________________ Date Last Seen: __________
Current Treatment/Medications: ____________________________
   Side Effects: ____________________________

Specialist's Name: ____________________________ Specialty: __________
Address: _____________________________________
Phone: ____________________________ Date Last Seen: __________
Current Treatment/Medications: ____________________________
   Side Effects: ____________________________

**HOSPITALIZATION/TREATMENT**

Please list all hospitalizations within the last 2 years:

Facility: ____________________________ Dates: ____________________________
Address: ____________________________
Condition treated: ____________________________

Facility: ____________________________ Dates: ____________________________
Address: ____________________________
Condition treated: ____________________________

To the best of my knowledge, the information I have provided is complete and correct.

Applicant Signature/Date: ____________________________
DORS Vendor of Assistive Technology Services

✓ The Arc Baltimore specializes in Assistive Technology for people with intellectual and developmental disabilities (I/DD).
✓ DORS consumers with I/DD can be referred to The Arc for AT assessments, setup and training.
✓ By authorizing The Arc to provide AT services to our own clients, the consumer benefits from:
  o Prompt communication and service provision
  o Holistic approach involving support team from beginning to end
  o Training materials (ex. videos, guides)
  o Follow through on implementation via Individual Plan integration and monitoring
✓ In order for The Arc Baltimore to provide AT services to DORS consumers, the DORS Counselor must provide the service authorization to The Arc Baltimore.
✓ DORS may also refer consumers to The Arc for AT services who are not involved in any of The Arc’s programs.

Examples of Assistive Technology for people with I/DD:
✓ Apps for task cueing, visual checklists and/or schedules (ex. Pictello, First Then Visual Schedule)
✓ Alerts (ex. VoiceCue, talking alarm clock)
✓ Computer access hardware and software (ex. Zoomtext, Dragon, WordQ, joystick mouse)
✓ Voice Recorders/smart pens
✓ Communication devices (ex. iPad apps, speech generating devices). The Arc can provide AT training and setup once a written assessment by a licensed SLP is obtained, but an SLP should provide assessment. (Ex. Individual already had an SLP assessment, The Arc can setup and train).
✓ Timers
✓ Switches (ex. ribbon switch)
✓ Environmental control and access (Amazon Echo, remotes)
✓ Vision supports (ex. magnifiers, puff paint/tactile labels)
✓ Hearing supports (ex. assistive listening devices)
✓ Any device, low or high tech, with the right features to help the individual overcome barriers and achieve their goals

Contact:
AT Lead
The Arc Baltimore, 7215 York Rd. Baltimore MD 21212
atechnology@thearcbaltimore.org / 410-296-2272 ext. 5319
https://www.thearcbaltimore.org/programs/assistive-technology/

Achieve with us.
Assistive Technology and Home Modification Program
Application

Name: ____________________  Date of Birth: ____________

Address: 
__________________________  Age: ______
__________________________  Disability: ____________________

Phone: _______________  County: ____________________

Annual Household Income: _______________
(For determination purposes only)

Technology or Modification Request, select one

☐ Hearing Aid
☐ Portable Ramp
☐ Permanent Ramp
☐ Stair Glide
☐ Bathroom Modification
☐ Doorway Widening
☐ Vehicle (Modification or otherwise)
☐ Other: ____________________

For Home Modification Requests Only

Do you own your home? ☐ Yes  ☐ No

Do you currently have any home modifications? ____________________

Do you plan to move in the next 12 months: ☐ yes  ☐ no

I understand that completion of this application do NOT guarantee funding.

Signature: ____________________

For Office Use Only:
Application Received: _________  By: _____________
The Arc Baltimore
Assistive Technology Referral Form

Individual Information

First Name: ___________________  Last Name: ___________________
Date of Birth: ___________________  Today's Date: ___________________
Diagnosis: ___________________  Age: ___________________
Home Address: ___________________  Home Phone: ___________________
Work Address: ___________________  Work Phone: ___________________
Cell Phone: ___________________  Email Address: ___________________

Referral Information

Person Making Referral: ___________________
Relationship to Individual: ___________________
Address If different from Individual: ___________________
Phone: ___________________
E-Mail Address: ___________________

Please describe the reason for Assistive Technology Referral:

________________________________________

Please describe any current or previous use of Assistive Technology:

________________________________________

Please list general availability for appointment:

________________________________________

Desired Appointment Location:
☐ The Arc Baltimore
  7215 York Road, Baltimore MD 21212
☐ Other: ___________________

Is the individual currently served in The Arc Baltimore’s programs?  ☐ Yes  ☐ No
**Billing Information**

Assistive Technology Service Fees:
- Assistive Technology Assessment: $250.00
- Assistive Technology Configuration/Training: $75.00/hour
- Name of device:
- Travel fees for any service outside of The Arc Baltimore: $20.00/hour

Please indicate where to send the invoice:

- [ ] Individual
- [ ] Person making referral
- [ ] Other: ________________________________

Send invoice via:

- [ ] Email
- [ ] Mail

**Signatures**

Individual
Signature: ___________________________ Date: _______________
Guardian
Signature if applicable: ___________________________ Date: _______________

Please return this completed referral form to The Arc Baltimore's Assistive Technology Department by:

Mail:
The Arc Baltimore
7215 York Road
Baltimore MD 21212
ATTN: Kelly Bell

Fax:
443-279-3422

Email:
atechntology@thearcbaltimore.org

You will be contacted to schedule an appointment. Thank you!

**Achieve with us.**
MARYLAND STATE LIBRARY FOR
THE BLIND
AND PHYSICALLY HANDICAPPED

APPLICATION FOR FREE LIBRARY SERVICE

The Maryland State Library for the Blind and Physically Handicapped in
Baltimore provides library service to all eligible citizens of Maryland under
the direction of the National Library Service for the Blind and Physically
Handicapped of The Library of Congress and the Division of Library
Development and Services of the Maryland State Department of
Education.

Regional Library

Maryland State Library for the Blind
and Physically Handicapped
415 Park Avenue
Baltimore, Maryland 21201

Voice
(410) 230 – 2424
(800) 964 – 9209

TTY
(410) 333 – 8679
(800) 934 – 2541

Web Page – www.lbph.lib.md.us
Email – referenc@lbph.lib.md.us
OPAC (Online Public Access Catalog) www.klas.com/talkingbooks/md
[ ] By law, preference in lending of books and equipment is given to veterans. Please check here if you have been honorably discharged from the armed forces of the United States.

ELIGIBILITY CRITERIA FOR LOAN OF LIBRARY MATERIALS

A. The following persons are eligible for loan service:
   1. Blind persons whose visual acuity, as determined by a competent authority, is 20/200 or less in the better eye with correcting lenses, or whose widest diameter of visual field subtends an angular distance no greater than 20 degrees.

   2. Other physically handicapped persons as follows:

      (a) Persons whose visual disability, with correction and regardless of optical measurement, is certified by a competent authority as preventing the reading of standard printed materials.

      (b) Persons certified by a competent authority as unable to read or unable to use standard printed material as a result of physical limitations.

      (c) Persons certified by a competent authority as having a reading disability resulting from organic dysfunction and of sufficient severity to prevent their reading printed material in a normal manner.

B. In cases of blindness, visual disability, or physical limitations, "competent authority" includes doctors of medicine; optometrists; professional staff of hospitals institutions, and public or welfare agencies (e.g., social workers, case
workers, counselors, rehabilitation teachers, and superintendents). In the absence of any of these, certification may be made by professional librarians.

C. IN THE CASE OF READING DISABILITY FROM ORGANIC DYSFUNCTION, COMPETENT AUTHORITY IS DEFINED AS DOCTORS OF MEDICINE AND DOCTORS OF OSTEOPATHY...

Indicate the primary disability preventing you from reading standard printed material. Check ONLY one box.

[ ] BLINDNESS
[ ] VISUAL DISABILITY
[ ] PHYSICAL DISABILITY
[ ] READING DISABILITY
[ ] DEAF AND BLIND

CERTIFYING AUTHORITY
Competent authorities may be professionals in a number of related fields (other than a member of the applicant’s family) who are familiar with the applicants' visual or physical conditions and are able to certify that the applicants are unable to read or use standard printed material because of the condition.

NAME: __________________________________________________________

TITLE/OCCUPATION: ____________________________________________

AGENCY: _______________________________________________________

ADDRESS: ______________________________________________________

_______________________________________________________________

TELEPHONE: ____________________________________________________

EMAIL ADDRESS: ______________________________________________

CERTIFIER’S SIGNATURE: _________________________________________
BASIC SERVICE - BOOKS AND EQUIPMENT

BOOK FORMATS:
[ ] Digital / Cassette
[ ] Braille
[ ] Large Print

MAGAZINES
FORMATS
[ ] Audio
[ ] Braille

Equipment:
Individuals who request audio books will automatically be sent a Digital Talking Book Player.

ADAPATIVE ACCESSORIES FOR THE HEARING IMPAIRED OR PEOPLE WITH PHYSICAL DISABILITIES ARE AVAILABLE UPON REQUEST.

Reading Preferences

[ ] Do not select books for me, I only wish books to be sent when I contact the library directly.

[ ] I wish to have books selected for me in the categories checked below:

[ ] Adventure    [ ] Fantasy    [ ] Plays
[ ] Adventure Nonfiction    [ ] Fine Art    [ ] Philosophy
[ ] Animal Stories    [ ] Gothic Novels    [ ] Poetry
[ ] Bestsellers Fiction    [ ] Historical Novels    [ ] Politics
[ ] Bestsellers Nonfiction    [ ] History    [ ] Psychology
[ ] Biographies    [ ] History, United States    [ ] Religion
[ ] Black / African American Interest    [ ] Humor    [ ] Romance
[ ] Christian Fiction    [ ] Literature    [ ] Science
[ ] Classics    [ ] Maryland Interest    [ ] Science Fiction
[ ] Cooking    [ ] Medicine & Health    [ ] Sports
[ ] Detective    [ ] Music and Dance    [ ] Travel
[ ] Family Saga    [ ] Mystery    [ ] Westerns
I do not want to receive books with the following:

[ ] Strong Language  [ ] Violence  [ ] Explicit Descriptions of sex
[ ] I do not want any reading restrictions

How many books would you like to receive in one month?

[ ] 5  [ ] 10  [ ] 15  [ ] 20  [ ] Specify ___

How often would you like to receive them?

[ ] Daily  [ ] Weekly  [ ] Monthly

How many would you like to be sent at one time?

[ ] 2  [ ] 5  [ ] 10  [ ] 20  [ ] Specify ___

How would you prefer to receive communications from us?

[ ] Mail  [ ] Large print  [ ] Braille  [ ] Cassette  [ ] E-mail

How did you hear about us?

[ ] Radio  [ ] Newspaper  [ ] Internet  [ ] Brochure
[ ] Health Care Provider  [ ] Word of Mouth
[ ] Other ____________________________
Discontinuation/Refusal of Assistive Technology

Use this form to document that the team has discussed Assistive Technology and the individual would like to waive access to Assistive Technology devices/services at this time. For people who have devices, refer to The Arc Baltimore’s Assistive Technology Policy before discontinuing AT, excerpt below.

In some cases, it may be appropriate to discontinue the use of recommended AT. Prior to device abandonment, the team:

- obtains consent of the individual;
- ensures that the device is in working order;
- ensures that all staff have been adequately trained;
- ensures that the individual has received adequate training and support. This includes documenting efforts on datasheets and/or progress reports;
- consults with AT Department for any additional recommendations;
- gathers written team agreement; and
- considers re-assessment.

INDIVIDUAL NAME: _______________________________ DATE: __________________

SIGNATURE: ________________________________

GUARDIAN SIGNATURE IF APPLICABLE: ________________________________

WITNESS NAME: ________________________________

WITNESS SIGNATURE: ________________________________