

Smoke Alarm Awareness and Education Program Application

Specialized Smoke Alarms for Individuals who are Deaf or hard of hearing

Date: _____

Program participants are expected to:

- Be a Phoenix-metro area resident with a documented hearing loss
- Demonstrate financial need
- Live in a single family dwelling

If you feel that you meet these requirements, please answer all questions below.

Applicant Information

Last name: _____ First name: _____ Middle Initial: _____

Street Address: _____ City: _____ Zip: _____

Main Phone: _____ Circle type of phone: TTY VP CapTel VCO Voice

Alternate Phone: _____ Circle type of phone: TTY VP CapTel VCO Voice

Cell Phone: _____ Can you send/receive text messages on your cell? (Y/N) _____

Email address: _____ DOB: _____ Male Female

Please describe your financial need:

Number of people living in the home: _____

Total monthly income of all people in your home: _____

Contact Person – Provide a contact person if you need assistance with scheduling the smoke alarm installation.

Last name: _____ First name: _____ Middle Initial: _____

Street Address: _____ City: _____ Zip: _____

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Contact Person – continued

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Relationship to Applicant: _____

If you are approved for a smoke alarm installation, what is the best way to contact you
Mon-Fri, 8a – 5p?

- Phone
- Email
- Contact Person listed above

Residence Information – please check appropriate boxes.

How many total people live in the home? _____

Are there multiple Deaf individuals living in the home? (Y/N) _____ If Yes, how many? _____

Are there any smoke alarms currently in the home? (Y/N) _____ If Yes, how many? _____

Primary Language:

- English
- American Sign Language
- Other: _____

If your application is approved, what is your situation regarding an ASL interpreter when an
installer comes to your home?

- I do not need an ASL interpreter.
- I have someone who can interpret for me.
- I need an ASL interpreter.

Do you need the installer to use an Assistive Listening Device when he or she comes to your home?
(Y/N) _____

Do you have a seizure disorder that might be triggered by a strobe light? (Y/N) _____

