What is the DDTP's role in distributing Speech Generating Devices (SGDs)?

The California Public Utilities Commission (CPUC), as part of its Deaf and Disabled Telecommunications Program (DDTP), provides SGDs as the provider of last resort for California residents needing Speech Generating Devices (SGD) pursuant to California Public Utilities Code Section 2881. The SGDs covered by this application are those identified as durable medical equipment by the United States Department of Health and Human Services. Applicants for this funding need to have been evaluated by a speech language pathologist.

How much financial assistance will the DDTP provide?

As the provider of last resort, the CPUC's DDTP will provide funding, in part or in whole, for the purchase of an SGD and its associated accessories, mounting system, and applicable telecommunications component. The DDTP will fund those SGD expenses that are not otherwise covered by public (e.g., Medicare, Medicaid, and Medi-Cal) or private insurance. For example, if an applicant's only available source of funding is Medicare, and Medicare only covers 80% of the cost for an SGD and its accessories, mounting system, and applicable telecommunications component, the SGD applicant may apply to the CPUC's DDTP for funding of the remaining 20%.

What does this SGD application package contain?

This is an application package for funding from the DDTP to purchase an SGD and its associated accessories, mounting system and applicable telecommunications component. This application package contains:

	Description	Action
1.	Application Package Instructions—pages 1 and 2	Applicant Keeps
2.	Application Form (Sections 1, 2, 3, 4, and 5)	Applicant submits to the CPUC
3.	Application Form (Sections 6 through 8)	SGD Provider/Manufacturer provides to the CPUC at the request of the Applicant
4.	"Authorization for Release of Information" form (2 copies): This form authorizes the CPUC to access the SGD applicant's personal medical information.	Applicant submits one copy to the CPUC, and one copy to the SGD provider/manufacturer.
5.	"Release Letter to SGD Provider/Manufacturer." (2 copies) This letter authorizes the SGD Provider/Manufacturer to release the SGD applicant's supplemental documentation required in Section 8 of the application to the CPUC.	Applicant submits one copy to the SGD provider/manufacturer, and one copy to the CPUC.
6.	"Applicant Responsibility Letter." Outlines the applicant's responsibilities for ownership and maintenance of the SGD, accessories, mounting system, & telecommunications component.	Applicant submits to the CPUC & retains a copy of this & other documents for their records.

Who may apply and benefit from this program?

California residents requiring an SGD for access to, and use of, the telephone network.

What does an SGD applicant need to do before applying for funding from this program?

To-Do Task 1: Seek and receive a completed, written evaluation report from a speech language pathologist (SLP) demonstrating the need for an SGD for access to and use of the telephone network.
To-Do Task 2: Seek and receive a prescription for an SGD from a licensed physician or other medical professional.
To-Do Task 3: Determine the amount of funds to be received from other public and private sources aside from the DDTP.
To-Do Task 4: Identify unfunded amount being requested from the DDTP.

What does an SGD applicant need to do as part of applying for funding from this program?

To-Do Task 1: Seek and receive the SLP's signature as part of completion of Section 3.
To-Do Task 2: Ensure completion of Section 4 identifying who is responsible for set-up.
To-Do Task 3: Ensure that Section 5 is complete and signed by the applicant or family contact/legal guardian identifying the amount of funds requested from the DDTP.

What does an SGD applicant need to do after submitting an application which is complete and has been signed by both the applicant or family contact/legal guardian, and speech language pathologist?

To-Do Task 1: Submit release letter to SGD provider.
To-Do Task 2: Check mailbox for the Acknowledgement Letter from the CPUC.
To-Do Task 3: After approval, coordinate delivery of SGD with SLP, SGD provider, or others as necessary for set-up of SGD, and associated accessories, mounting system, and applicable telecommunications component.

What is the address to which relevant application and required supplemental documentation should be sent?

California Public Utilities Commission
Attn: DDTP Speech Generating Device Application
Communications Division
505 Van Ness Ave. San
Francisco, CA 94102

Will my information be kept confidential?

As indicated in the enclosed "Authorization for Release of Information" form, the CPUC will handle all information that it receives confidentially in compliance with all applicable federal and state laws.

Who do I contact if I have questions?

For any questions concerning your application, please call 800-900-3985, or send an email to **ddtp-sgd-application@cpuc.ca.gov**. For copies of this application and instructions, please visit www.cpuc.ca.gov under the Communications Division then choose "WHAT'S NEW in Communications". A link is also located at the DDTP website: www.ddtp.org.

Sections 1 and 2: To be completed and signed by the applicant or family contact/legal guardian.

SECTION 1: THE APPLICANT This is the person who will be receiving the equipment or services.		
First Name:	Middle:	Last:
Primary Place of Residence Address:		
City:	State:	Zip Code:
P.O. Box (if applicable):		
City:	State:	Zip Code:
E-mail Address:	Home Phone: ( )	Alternate Phone Number: ( )
Type of Primary Place of Residence ☐ Home ☐ Custodial Facility (assisted living) ☐ Intermediate Care Facility ☐ Skilled Nursing Facility ☐ Hospice Program ☐ Group Home ☐ Inpatient Hospital ☐ Other (specify) _____		
Name of Group Home or Facility:		Group Home or Facility Phone: ( )
Anticipated primary location of SGD if different from "Primary Place of Residence" above:		
Street Address:		
City:	State:	Zip Code:

SECTION 2: FAMILY CONTACT/LEGAL GUARDIAN The **legal guardian** or **family contact** is the person who is the emergency contact or who is assisting the applicant.		
First Name:	Middle:	Last:
Relationship to the Applicant/Client: ☐ Spouse ☐ Parent ☐ Legal Guardian ☐ Child ☐ Other (please specify below) ☐ Power of Attorney (Check all that apply)		
Street Address:		
City:	State:	Zip Code:
PO Box (if applicable):		
City:	State:	Zip Code:
E-mail Address:	Phone ( )	Fax ( )
Emergency Phone: ( ) Emergency Contact Name:	**THIS EMERGENCY PHONE MUST BE DIFFERENT FROM THE APPLICANT'S HOME PHONE NUMBER** ☐ Check here if different number is not available	

Section 3: To be completed and signed by the speech language pathologist (SLP).

SECTION 3: THE SPEECH LANGUAGE PATHOLOGIST The **SLP** is the clinician who performed the evaluation of the applicant and provided the written report.		
SLP First Name:	SLP Last Name:	SLP Phone: ( )
SLP Fax: ( )	SLP Alternate Phone: ( )	SLP Alternate Fax: ( )
Facility/Practice Name:	Facility/Practice Phone: ( )	
Business Street Address:		
City:	State:	Zip Code:
PO Box (if applicable):		
City:	State:	Zip Code:
E-mail Address:	SLP License #	
Alternate Contact Name:	Alternate Contact Phone: ( ) Alternate Contact E-mail Address:	
I have completed an assessment/evaluation and am recommending an SGD for the person identified below. Based on my evaluation, this SGD meets his/her needs for access to, and use of, the telephone network. _____ Print Full Name of Applicant/Client		
X_____ Signature of SLP	Date: _____	

SECTION 4: SGD SET-UP Additional information to be provided by **applicant or family contact/legal guardian, speech language pathologist, or SGD provider**. Based on treatment plan for the applicant/client, the following persons are to be involved in set-up of the following:		
DESCRIPTION	RESPONSIBLE INDIVIDUAL	PHONE NUMBER OR EMAIL
SGD Device		
SGD Accessories, including any software		
SGD Mounting System		
Applicable Telecommunications Component		

It is the CPUC's understanding that the applicant or family contact/legal guardian will coordinate with the speech language pathologist and SGD provider on the set-up of the SGD and associated accessories, mounting system, and applicable telecommunications component, and required training.

SECTION 5: ADDITIONAL APPLICANT INFORMATION To be completed and/or provided by **the applicant** or family contact/legal guardian
In addition to returning this application signed by the applicant or family contact/legal guardian, and signed by the Speech Language Pathologist, the applicant or family contact/legal guardian is to sign and return the attached CPUC Release Form. The applicant understands that he/she is the intended recipient and owner of the SGD (device, accessories, mounting system, and applicable telecommunications component) for which funding from the DDTP is being requested. The applicant and/or family contact/legal guardian has identified any applicable public or private insurance and understands that the DDTP is the provider of last resort.
Based on an estimate of funding available, I, the applicant, _____ am requesting $_____ funds from the California Public Utilities Commission's Deaf and Disabled Telecommunications Program. I certify that the information provided herein regarding funding is complete and accurate.
Sections 6 through 8 contain additional information and supplemental documentation required to support the applicant's SGD application. This information must be provided to the CPUC at the address provided on the last page of this application by the SGD provider at the request of the applicant or family contact/legal guardian unless the applicant or family contact/legal guardian provides directly. Please indicate whether the SGD provider or by the applicant or family contact/legal guardian will be completing Sections 6 through 8 by checking the appropriate box below. ☐ The **SGD Provider /Manufacturer** will complete Sections 6 through 8 ☐ The **Applicant/Family Contact/Legal Guardian** will complete Sections 6 through 8
X_____ Date: _____ Signature of Applicant/Family Contact/Legal Guardian

SECTION 6: PHYSICIAN OR OTHER MEDICAL PROFESSIONAL PROVIDNG SGD PRESCRIPTION This section identifies the physician or other medical professional providing the SGD prescription. This information is to be provided to the CPUC at the address below by **the SGD Provider/Manufacturer** at the request of the applicant unless the applicant or family contact/legal guardian provides directly.		
Physician First Name:	Physician Last Name:	
Practice Name:		
Street Address:		
City:	State:	Zip Code:
PO Box (if applicable):		
City:	State:	Zip Code:
E-mail Address:	Phone ( )	Fax ( )
Doctor Medicaid Provider #	Doctor License #	Doctor NPI#
Medicaid Primary Care Physician Name:	Phone: ( )	

SECTION 7: THE SGD PROVIDER/MANUFACTURER To be completed and/or provided to the CPUC at the address below by **the SGD Provider/Manufacturer** at the request of the SGD applicant unless the SGD applicant or family contact/legal guardian provides directly.		
SGD Provider/Manufacturer Name:		
Street Address:		
City:	State:	Zip Code:
Phone Number: ( )	Fax Number: ( )	
SGD Provider/Manufacturer Contact Person Name and Job Title:		
Phone Number: ( )	Fax Number: ( )	E-mail Address:

Section 8: LIST OF REQUIRED COPIES OF SUPPLEMENTAL DOCUMENTATION
To be completed and/or provided to the CPUC at the address below by **the SGD Provider/Manufacturer** at the request of the SGD applicant unless the SGD applicant or family contact/legal guardian provides directly.

The following items are required and must be provided by the SGD manufacturer if the applicant/client is unable to provide. Apply a check mark to the boxes below to confirm that these required documents are included with this application, or otherwise provided to the CPUC under separate cover. Any missing or incomplete items may result in a delay in the processing of this application or rejection.

☐ Completed Client Information Form

☐ Completed SLP Evaluation Report

☐ SGD Prescription

☐ Detailed Quote, including make, model, and price of equipment, including the SGD device, accessories, mounting system, and telecommunications component.

☐ Primary or other Insurance Approval Letter for partial payment (where applicable)

☐ Primary or other Insurance Letter denying services (where applicable)

☐ Explanation of Benefits/Payments from Primary and other Insurance showing payment made (where applicable)

☐ Calculation of balance due to be paid by the CPUC's Deaf and Disabled Telecommunications Program

I certify that the information provided in Sections 6 through 8 above is accurate, true, and complete to the best of my knowledge.

X_____ Date: _____
Signature of Authorized SGD Provider/Manufacturer or Applicant, Family Contact, or Legal Guardian

This information is to be mailed to:

California Public Utilities Commission
Attn: DDTP Speech Generating Device Application
Communications Division
505 Van Ness Ave.
San Francisco, CA 94102