

"Fire Safety Solutions for Marylanders who are Deaf or Hard of Hearing" Alarming Device Application

Date of Application: _____ Device #: _____

To participate in this program, you must

- Answer all questions, on both the front and back sides of this form
- Be a Maryland resident with a hearing impairment
- Provide proof of your need (letter from doctor, medical provider, audiologist, professional, etc.)
- NOT live in an institutional facility (dorm, nursing home, etc.)

Applicant (Person needing alarm)

Last Name: _____ First Name: _____ Md. Initial: _____

Street/Mailing Address: _____ City: _____ Zip: _____

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

Email address: _____ Is Email a good way to contact you? ☐ Yes ☐ No

Date of Birth: _____ ☐ Male ☐ Female County: _____

Contact Person / Guardian

Please provide a **contact person** if you need assistance with scheduling the alarming device installation.

Last Name: _____ First Name: _____ Md. Initial: _____

Street Address: _____ City: _____ Zip: _____

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

Relationship to Applicant: _____

Did someone prepare this application for you? ☐ No ☐ Yes, _____ [name]

Preparer's Phone: _____ Email address: _____

Residence

Check the answer to the following questions. Your answers will help us know if additional smoke alarms are needed.

1. Type of residence:

- ☐ One family
- ☐ Multi-family
- ☐ Apartment
- ☐ Mobile home

3. Number of levels (stories) in the home:

- ☐ One
- ☐ Two
- ☐ Three or more

5. In what room or area does the person with a need sleep?

2. Is this your permanent residence?

- ☐ Yes
- ☐ No

4. How many people live in the household?

6. Number of smoke alarms currently in the home:

- ☐ Zero
- ☐ One
- ☐ Two
- ☐ Three or more

Please turn over and complete the other side of this application

7. Is there at least one smoke alarm on every level of the home?

- ☐ Yes
☐ No

8. If no, which level(s) does not have a smoke alarm?

9. Is there at least one smoke alarm near all sleeping areas?

- ☐ Yes
☐ No

Alarm Need

1. Check the reason for which you need the alarm.

- ☐ Deaf
☐ Hard of Hearing

2. Primary Language:

- ☐ English
☐ American Sign Language (ASL)
☐ Other: _____

4. If you selected deaf or hard of hearing, do you have a seizure disorder that might be triggered by a strobe light?

- ☐ Yes
☐ No

3. What is your situation regarding an interpreter when an installer comes to your home?

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

5. What is your preferred format for home fire safety messages?

- ☐ Standard Print
☐ Large Print
☐ CD
☐ DVD in American Sign Language
☐ Internet / Website

Information collected is kept confidential and used for follow-up by FABSCOM only.

What is the best way to contact you?

- ☐ Phone—List the phone number where we can call you Monday-Friday 8:00 am - 5:00 pm
Phone: _____ TTY? ☐ Yes ☐ No Video Phone ☐ Yes ☐ No
☐ Email—Email address: _____
☐ Contact Person as listed previously

After your alarming device is approved, you will be contacted to arrange a time for installation.

Mail, E-mail or Fax this completed application and your proof of need to:

FABSCOM - Debbie Gartrell

3971 Hooper Road

New Windsor, MD 21776

Phone: 410-795-1333 x336 Fax: 410-795-1375

Email: debbiegartrell@comcast.net

For more information, please visit our website: www.fabscom.org

This program is operated on limited funding and generous donations. We ask those who are capable, please donate to this needed program to help those less fortunate. These devices retail for approximately \$300.00 each. Any contributions to offset the costs are greatly appreciated. Thank you!

Make contributions payable to: **FABSCOM – DHH Fund**