

CCTV RENTAL APPLICATION

Name:

Address:

City:

State:

Zip:

Birthdate:

Social Security Number:

Phone: Home ()

Work: ()

Email Address:

1. How did you hear about the CCTV Loan Program?

- Department of Services for the Blind Independent Living Provider
- School District
- College Program
- Other (Please Describe): _____

2. Are you currently receiving services from:

- Department of Services for the Blind (DSB)
- Division of Vocational Rehabilitation (DVR)
- School District or College
- None of the above

3. Vision loss Diagnosis (Check all that apply):

- Macular Degeneration
- Glaucoma
- Diabetic Retinopathy
- Retinopathy of prematurity
- Retinitis Pigmentosa
- Usher's Syndrome
- Other (Please describe)

4. What type of CCTV are you requesting?

- | | | |
|-------|---------------|------------|
| _____ | Black & White | \$25/month |
| _____ | Color | \$35/month |
| _____ | Not Sure | |

Do you need help choosing the model that will work best for you?

- Yes
- No

5. Do you have household or renters insurance?

- Yes
- No

If yes, please identify the name of your insurance company, policy number and agent's name and phone number. If possible, attach a copy of the cover page.

6. Please describe how you hope to use the CCTV and how it will help you in every day life.

3/17/20092

7. Please provide names and contact information for two personal references.

Reference # 1:

Name:

Address:

City:

State:

Zip:

Phone: Home ()

Work ()

Email Address:

Reference # 2:

Name:

Address:

City:

State:

Zip:

Phone: Home ()

Work ()

Email Address:

Authorization/Certification

I certify that the information provided in this application is true to the best of my knowledge. Authorization is hereby given for the release of any and all information concerning bank accounts, employment, credit or mortgage verification as requested by the Washington Assistive Technology Foundation if needed to determine my eligibility and to verify my need for the support which I am requesting. I authorize the release of such confidential information.

Signature of Applicant

Date

Name & Contact Information of Individual Who Assisted with Application (if any):

3/17/20094

ATTACHMENTS

- 1. Demographic Information: This information is used solely by WATF to determine who we are serving.**
- 2. CCTV Rental Agreement: This agreement needs to be signed before we can rent out a CCTV.**
- 3. Electronic Funds Transfer (to set up automatic rental payments): This document authorizes our organization to set up your rental payment through electronic funds transfer. It is not a requirement to rent a CCTV but we prefer this method of payment because it reduces paperwork and makes it easier for everyone!**

3/17/20095

DEMOGRAPHIC INFORMATION

This background information helps us to determine who we are serving. It will be kept confidential and in no way impacts the services you will receive. We also will ask you to participate in a brief follow-up survey once you have received your CCTV.

Age:

Gender:

- Male
- Female

Ethnic/Racial Background:

- Caucasian
- Hispanic
- Asian/Pacific Islander
- African American
- Native American
- Other (Please Describe):

Language Spoken At Home:

- English
- Spanish
- Chinese
- Korean
- Vietnamese
- Other:

3/17/20096

Marital Status:

- Single with no dependent children
- Single with dependent children
- Married or Domestic Partnership
- Divorced
- Widowed
- Other (please describe)

Employment Status:

- Employed Fulltime
- Employed Part-time
- Unemployed
- Retired on disability
- Retired
- Student: High School ___ College ___ Other ___
- Homemaker
- Other (Please describe)

Are you actively seeking work?

- No
- Yes - Fulltime
- Yes - Part-time

Do you have disabilities other than vision loss?

- No
- Yes. If yes, please describe

Housing Status:

- Subsidized Rental Unit
- Rent
- Buying or own Home or Condo
- Other (Please describe):

3/17/20097

Gross Monthly Personal Income: \$ _____

Sources of Income:

- Employment:** \$ _____
- SSI/SSDI:** \$ _____
- Social Security:** \$ _____
- Savings/Investments:** \$ _____
- Pension/401K:** \$ _____
- Other Disability**
- Income:** \$ _____
- Trust:** \$ _____
- Other (Describe):** \$ _____

Number of Persons Supported on this Income: _____

WATF CCTV RENTAL AGREEMENT

This agreement is entered into this ___ day of ____, 200__

between the Washington Assistive Technology Foundation

("WATF") and _____ (User). User hereby agrees to

pay the Washington Assistive Technology Foundation ("WATF")

\$_____ per month ("monthly payment") for rental of a Closed

Circuit TV. User further agrees that:

a) s/he will maintain insurance on the CCTV while it is in User's possession and will provide proof of insurance to WATF on an annual basis. If you do not have insurance, WATF will help you to obtain it.

b) s/he will notify WATF in writing 20 days prior to any change of address, insurance coverage or bank account;

c) s/he will maintain the equipment in good condition and will pay for any damage to the equipment other than normal "wear and tear";

d) s/he will surrender the CCTV to WATF in good condition when no longer needed.

If User fails to make any payment when due or to meet any other requirement, the Agreement will be terminated and the equipment will be returned, in good condition, upon demand, to the Washington Assistive Technology Foundation.

Dated this _____ day of _____, 200__.

User

Method of Payment:

Automatic Funds Transfer (preferred) on the ____ day of the Month.

Check or Money Order on the ____ day of the Month.

Authorization Agreement for Direct Payments (ACH Debits)

Name(s): _____

I/we hereby authorize **WASHINGTON ASSISTIVE TECHNOLOGY FOUNDATION**, herein after called the Company, to automatically withdraw funds from my/our Checking Account Savings Account (select one) in the amount of \$ _____ **per month for rental of a CCTV.** I agree that my account will be debited on the _____ **of each month** and that it is my responsibility to ensure that sufficient funds are in my account at that time. I understand that if my payment is returned for "Not Sufficient Funds", I will be responsible for paying a **\$10.00** returned item fee. I understand that I will be notified of changes in the payment amount at least ten (10) calendar days in advance of the scheduled payment date. I agree that in the event of an incorrect amount or entry, I authorize the Company to process a correcting entry.

Financial Institution _____

Transit Routing/
ABA Number _____ Account Number _____

This authority will remain in effect until I instruct the Company in writing to change or cancel this authorization 10 days prior to the date funds are to be debited from my account.

Signature: _____

Date: _____

Signature: _____

Date: _____

**Please attach a sample VOIDED
CHECK here**

3/17/200911