



Deaf & Hard of Hearing Free Smoke Alarm Program ORDER FORM

Complete one form per individual and return to OSFM, kelly.ingold@ks.gov or Fax #785-296-0151.
Mail: 800 SW Jackson, Suite 104, Topeka, KS 66612-1216. Call 785-291-3586.

Date: _____

REQUESTOR INFORMATION

To participate in the program you must...

- Answer all the questions on this form
- Be a Kansas resident over the age of four
- NOT live in an institutional facility (nursing home, hospital, etc.)

Recipient Name: _____ Contact Name (if different) _____

Street Address: _____

City: _____ County: _____ ZIP: _____

Phone Number: _____ Date of Birth: _____

Email Address: _____

Alternate Contact: _____ Phone: _____

Local Fire Dept.: _____

REQUIRED INFORMATION

Select the answer to the following questions.

Requesting: Strobe by Gentex Bedside Shaker Both

1. Type of Residence: One Family Multi-Family Apartment Mobile Home

2. Primary Disability: Deaf Hard-of-Hearing

3. Primary Language: English ASL Spanish Other, specify: _____

4. Are there working smoke alarms in the home? YES NO

CERTIFYING PROFESSIONAL

I confirm this individual has hearing loss or is deaf.

Certifying Professional Name: _____

Certifying Professional Signature: _____

- Physician
- Audiologist
- Advanced Registered Nurse Practitioner
- Nurse Practitioner
- Physician's Assistant
- Speech Pathologist
- Vocational Rehabilitation Counselor