GET ALARMED KANSAS

Deaf & Hard of Hearing
Free Smoke Alarm Program

ORDER FORM

Complete 1 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.: _____

CERTIFYING PROFESSIONAL

I confirm this individual has a hearing loss or is deaf.

Name: _____

Signature: _____

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

ADDITIONAL INFORMATION

Select the answer to the following questions. Your answers will help us know which equipment meets your needs.

1. Requesting: ☐ Strobe by Gentex ☐ Bedside Shaker ☐ Both
2. Type of Residence: ☐ One Family ☐ Multi-Family ☐ Apartment ☐ Mobile Home
3. Primary Disability: ☐ Deaf ☐ Hard of Hearing
4. Primary Language: ☐ English ☐ ASL ☐ Spanish ☐ Other, specify: _____
5. Are there working smoke alarms in the home? ☐ YES ☐ NO