



The National Deaf-Blind Equipment Distribution Program

Application Section 1 of 3: Instructions and Guidelines

Overview

The National Deaf-Blind Equipment Distribution Program (NDBEDP) supports local programs that distribute equipment to low-income individuals who are deaf-blind (have combined hearing and vision loss) to enable access to telephone, advanced communications, and information services. This support was mandated by the Twenty-First Century Communications and Video Accessibility Act of 2010 (CVAA) and is provided by the Federal Communications Commission (FCC). For more information about the NDBEDP, please visit <http://icanconnect.org/colorado> or <http://www.fcc.gov/ndbedp>.

Who is eligible to receive equipment?

Under the CVAA, only low-income individuals who are deaf-blind are eligible to receive equipment provided through the NDBEDP. Applicants must provide verification of their status as low-income and deaf-blind.

Income eligibility

To be eligible, your family/household income must be below 400% of the Federal Poverty Guidelines, as shown in the following table (2014):

Number of persons in family/household	400% for Colorado
1	\$47,080
2	\$63,720
3	\$80,360
4	\$97,000
5	\$113,640
6	\$130,280
7	\$146,920
8	\$163,560
For each additional person, add	\$16,440

For purposes of determining income eligibility for the NDBEDP, the FCC defines “income” and “household” as follows:

“Income” is all income actually received by all members of a household. This includes salary before deductions for taxes, public assistance benefits, social security payments, pensions, unemployment compensation, veteran's benefits, inheritances, alimony, child support payments, worker's compensation benefits, gifts, lottery winnings, and the like. The only exceptions are student financial aid, military housing and cost-of-living allowances, irregular income from occasional small jobs such as baby-sitting or lawn mowing, and the like.

A “household” is any individual or group of individuals who are living together at the same address as one economic unit. A household may include related and unrelated persons. An “economic unit” consists of all adult individuals contributing to and sharing in the income and expenses of a household. An adult is any person eighteen years or older. If an adult has no or minimal income, and lives with someone who provides financial support to him/her, both people shall be considered part of the same household. Children under the age of eighteen living with their parents or guardians are considered to be part of the same household as their parents or guardians.

See Section 2 for the family/household income information that must be provided with this application.

Disability eligibility

For this program, the CVAA requires that the term "deaf-blind" has the same meaning given by the Helen Keller National Center Act. In general, the individual must have a certain vision loss and a hearing loss that, combined, cause extreme difficulty in attaining independence in daily life activities, achieving psychosocial adjustment, or obtaining a vocation (working).

Specifically, the FCC's NDBEDP rule 64.610(c)(2) states that an individual who is “deaf-blind” is:

(i) Any person:

(A) Who has a central visual acuity of 20/200 or less in the better eye with corrective lenses, or a field defect such that the peripheral diameter of visual field subtends an angular distance no greater than 20 degrees, or a progressive visual loss having a prognosis leading to one or both these conditions;

(B) Who has a chronic hearing impairment so severe that most speech cannot be understood with optimum amplification, or a progressive hearing loss having a prognosis leading to this condition; and

(C) For whom the combination of impairments described in . . . (A) and (B) of this section cause extreme difficulty in attaining independence in daily life activities, achieving psychosocial adjustment, or obtaining a vocation.

(ii) The definition in this paragraph also includes any individual who, despite the inability to be measured accurately for hearing and vision loss due to cognitive or behavioral constraints, or both, can be determined through functional and performance assessment to have severe hearing and visual disabilities that cause

extreme difficulty in attaining independence in daily life activities, achieving psychosocial adjustment, or obtaining vocational objectives.

An applicant's functional abilities with respect to using telecommunications, Internet access, and advanced communications services in various environments shall be considered when determining whether the individual is deaf-blind under . . . (B) and (C) of this section.

Who can attest to a person's disability eligibility?

A practicing professional who has direct knowledge of the person's vision and hearing loss, such as:

- Audiologist
- Community-based service provider
- Educator
- Hearing professional
- HKNC representative
- Medical/health professional
- School for the deaf and/or blind
- Specialist in Deaf-Blindness
- Speech pathologist
- State equipment/assistive technology program
- Vision professional
- Vocational rehabilitation counsellor

Such professionals may also include, in the attestation, information about the individual's functional abilities to use telecommunications, Internet access, and advanced communications services in various settings.

Existing documentation that a person is deaf-blind, such as an individualized education program (IEP), or a statement from a public or private agency, such as a Social Security determination letter, may serve as verification of disability.

See Section 3 for the disability attestation information that must be provided with this application.

Confidentiality policy

iCanConnect is committed to ensuring that your privacy is protected. Information provided on this application form will only be used to determine eligibility for iCanConnect products and services. iCanConnect will not sell, distribute or lease your personal information to third parties unless you give permission, or if the iCanConnect program is required by law to do so. iCanConnect is committed to ensuring that personal information is secure. In order to prevent unauthorized access or disclosure, suitable physical, electronic and managerial procedures are in place to safeguard and secure the information iCanConnect collects.

iCanConnect

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Application Section 2 of 3: Applicant's Personal Data

(Please fill in all fields)

Name: _____

Address: _____

Phone: _____ Voice TTY VP

Cell Phone: _____ Email: _____

Communication Preference:

Voice VP CapTel Cell Phone Email Fax

Date of birth: _____ Gender: _____

Number of People in Household: _____ Total Household Income : _____

Alternate Contact (in case of emergency): _____

Address: _____

Phone: _____ *Cell Phone:* _____ *Email:* _____

Alternate Contact's Communication Preference:

TTY VP CapTel Cell Phone Email Fax

(If you are under age 18, your parent or legal guardian must sign the application.)

Language preference: _____

State in which you are a permanent resident? _____

Feedback/suggestions (optional): _____

How did you hear about this program?

- iCanConnect.org website
- Disability advocacy group
- Education provider or School
- Family member or Friend
- Healthcare provider
- Helen Keller National Center (HKNC) representative or Specialist in Deaf-Blind Services
- Independent Living Center or Senior Center
- Media
- State Deaf-Blind Project
- Technology vendor
- Vocational Rehabilitation Counselor
- Other – _____

Income eligibility

Number of People in Household: _____

To confirm your income eligibility, please mail or fax documentation that proves your eligibility for one of the following federal programs:

- Medicaid
- Low-income home energy assistance
- Supplemental Security Income (SSI) (Social Security Award letter)
- Federal public housing assistance or Section 8
- Food Stamps or Supplement Nutrition Assistance Program (SNAP)
- Temporary Assistance for Needy Families (TANF) or Welfare to Work (WTW)
- National School Lunch Program's free lunch program

If none of the above apply, mail or fax a copy of the front page of last year's Federal IRS 1040 tax form(s) filed by you and members of your family/household, or send other evidence of your family/household income, such as recent Social Security Administration retirement benefit statement(s) or other pension benefit statement(s).

With my signature below I hereby request services and certify that:

- 1) the information I have provided in this application is true and accurate to the best of my knowledge;
- 2) the document(s) submitted represent the entire income for my family/household; and
- 3) I authorize the confidential release of the disability and income information I have provided for use solely as required for the administration of my application.

I acknowledge that I am subject to audit and if it is found that I have provided inaccurate information on this form, I will be prosecuted to the fullest extent allowable by law. Should I become eligible for services, I agree to use these services solely for the purposes intended. I further understand that I may not sell, mortgage, lend or transfer interest in any equipment or services provided to me. Falsification of any records or failure to comply with these provisions will result in the immediate termination of service.

Print name of applicant or parent/guardian (if applicant is under age 18):

Signature: _____ **Date:** _____



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Application Section 3 of 3: Disability Verification

This disability verification section is to be completed by a practicing professional who has direct knowledge of the applicant's vision and hearing loss.

Please complete the following fields, and sign and date at the bottom.

Name and Address of Deaf-Blind Individual (Applicant):

Name: _____

Street address: _____ **City/state/zip:** _____

Attester/Certifier:

Name: _____ **Title:** _____

Agency: _____

E-mail: _____ **Phone:** _____

Street address: _____ **City/state/zip:** _____

I certify under penalty of perjury that, to the best of my knowledge, this individual is deaf-blind as defined by the FCC in Section 1, above.

Signature: _____ **Date:** _____

Fax, e-mail, or mail completed application (Sections 1, 2 and 3) with proof of income to:

**JoAnne Hirsch, TEDP Coordinator
Colorado Commission for the Deaf and Hard of Hearing
1575 Sherman St., Garden Level
Denver, CO 80203**

E-mail: joanne.hirsch@state.co.us

Voice: 303-866-2097 **VP:** 720-949-7457 **Fax:** 303-866-4831

If scanned documents are submitted, please use PDF format.
(This document is available upon request in hard copy print, Braille, and electronic text.)