Application Section 1 of 4: Instructions and Guidelines

Overview
The National Deaf-Blind Equipment Distribution Program (NDBEDP) will ensure that low-income individuals who have combined hearing and vision loss can access telephone, advanced communications and information services. This program was mandated by the Twenty-First Century Communications and Video Accessibility Act of 2010 (CVAA), which authorizes the Federal Communications Commission (FCC) to provide funding for local programs to distribute equipment to low-income individuals who are deaf-blind (who have hearing loss and vision loss). For more information on the National Deaf-Blind Equipment Distribution Program (NDBEDP), please visit: http://www.icanconnect.org

Who is eligible to receive equipment?
Under the CVAA, only low-income individuals who are deaf-blind are eligible to receive equipment. Applicants must provide verification of their status as low-income and deaf-blind. The FCC defines "low income" to mean not more than 400% of the Federal Poverty Guidelines.

Income eligibility
To be eligible for iCanConnect, your household income must be below 400% of the Federal poverty level, as shown in the following table:

<table>
<thead>
<tr>
<th>Number of persons in family/household</th>
<th>400% for everywhere, except Alaska and Hawaii</th>
<th>400% for Alaska</th>
<th>400% for Hawaii</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>$47,520</td>
<td>$59,360</td>
<td>$54,680</td>
</tr>
<tr>
<td>2</td>
<td>$64,080</td>
<td>$80,080</td>
<td>$73,720</td>
</tr>
<tr>
<td>3</td>
<td>$80,640</td>
<td>$100,800</td>
<td>$92,760</td>
</tr>
<tr>
<td>4</td>
<td>$97,200</td>
<td>$121,520</td>
<td>$111,800</td>
</tr>
<tr>
<td>5</td>
<td>$113,760</td>
<td>$142,240</td>
<td>$130,840</td>
</tr>
<tr>
<td>6</td>
<td>$130,320</td>
<td>$162,960</td>
<td>$149,880</td>
</tr>
<tr>
<td>7</td>
<td>$146,920</td>
<td>$183,680</td>
<td>$168,920</td>
</tr>
<tr>
<td>8</td>
<td>$163,560</td>
<td>$204,480</td>
<td>$188,040</td>
</tr>
<tr>
<td>For each additional person, add</td>
<td>$16,640</td>
<td>$20,800</td>
<td>$19,120</td>
</tr>
</tbody>
</table>
For purposes of determining income eligibility for 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 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 FCC. 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 clauses (c)(2)(i)(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 clauses (c)(2)(i)(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 National Deaf-Blind 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

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.
Application Section 2 of 4: Applicant’s Personal Data

(Please fill in all fields)

Name: __________________________________________________________

Address: __________________________________________________________________________

Phone: ________________ Voice ____ TTY _____ VP ___

Cell Phone: ___________________ Email: ____________________________

Communication Preference: ___ TTY ___ VP ___CapTel ___ Cell Phone ___TRS ___ VRS ___ Email ___Fax

Alternate Contact (in case of emergency): ________________________________

Address: __________________________________________________________________________

Phone: ________________ Cell Phone: _________ Email: ____________________________

Alternate Contact’s Communication Preference: ___ TTY ___ VP ___CapTel ___ Cell Phone ___TRS ___ VRS ___ Email ___Fax

Date of birth: _______________   Gender: __________

Language preference: __________________________________________________________________

State in which you are a permanent resident? ________________________________

Are you over 18 years of age? Yes/No  (If no, your legal guardian must sign the application.)

Feedback/suggestions (optional): __________________________________________________________________

________________________________________________________________________________
How did you hear about this program?

___iCanConnect.org website  ___Interpreter
___Conference or seminar  ___Media/news
___Disability advocacy group  ___Medical provider
___Education provider/school  ___Senior Center
___Family member  ___Specialist in Deaf-Blind Services
___Friend  ___State Deaf-Blind Project
___Healthcare provider  ___Technology vendor
___Helen Keller National Center  ___Vocational Rehabilitation Counselor
 (HKNC)  ___Other professional
___HKNC rep  ___Other - general
___Independent Living Center

Income eligibility
To confirm your income eligibility, please mail or fax a copy of last year’s Federal 1040 IRS tax form, or send documentation that proves your eligibility for one of the following federal low-income programs:

_______ Medicaid
_______ Low income home energy assistance
_______ SSI
_______ Federal public housing assistance or Section 8
_______ Food Stamps or SNAP (Supplement Nutrition Assistance Program)
_______ Temporary Assistance for Needy Families (TANF) or Welfare to Work (WTW)
_______ If none of the above apply, last year’s Social Security Administration benefit statement or other pension benefit statement

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 benefit document(s) submitted represent the entire income for my 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 to iCanConnect.

I acknowledge that I am subject to audit and if I am found providing 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.

Name of applicant (print): _______________________________________________________

Signature of applicant/guardian: _____________________________ Date: _______________
Application Section 3 of 4: 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:
Name: ___________________________ Title: ________________________________
Agency: ________________________________________________________________
E-mail: ___________________________ Phone: ________________________________
Street address: _______________________________ City/state/zip: ______________________

I certify under penalty of the law that this individual is deaf-blind as defined above by the FCC.

Signature: ________________________________ Date: __________________
Application Section 4 of 4: Disability Information

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 of applicant: _____________________________________________________________

Qualifying Diagnoses___________________________________________________________

1. Does this applicant have a visual acuity of 20/200 or less or limited visual field as described in the guidelines?
   □ Yes. It is ____________________ . □ No
   Do you have a reason expectation that this applicant will progressively reach a visual acuity loss of 20/200 or limited visual field?
   □ Yes □ No

2. Does this applicant have a chronic hearing impairment where most speech is not understood with optimum amplification?
   □ Yes □ No

3. Does the combination of conditions listed in 1 & 2 (regardless of severity) cause difficulty with independence in daily living, psychosocial adjustment, or obtaining a vocation?
   □ Yes. Please explain_______________________________________________________
   □ No.
   (Attach extra sheets as necessary)

Disability verification provided by:

Name_____________________________ Professional Title _____________________________

E-mail_____________________________ Phone_______________________________________

Address____________________________________________________________________

iCanConnect Application Form (rev. 3/11/16) 7
Fax, e-mail, or mail completed application (Sections 1, 2, 3 and 4) to:

Wyoming Institute for Disabilities  
University of Wyoming  
1000 E. University Ave.  
Laramie, Wyoming  82071  
E-mail: walameda@uwyo.edu  
Fax: 307-766-2763  
Telephone inquiries: 800-888-9463

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