



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> 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:

2016 Federal Poverty Guidelines			
Number of persons in family/household	100% FPG	iCanConnect 400% Annually	iCanConnect 400% Monthly
1	\$11,880	\$47,520	\$3,960
2	\$16,020	\$64,080	\$5,340
3	\$20,160	\$80,640	\$6,720
4	\$24,300	\$97,200	\$8,100
5	\$28,440	\$113,760	\$9,480
6	\$32,580	\$130,320	\$10,860
7	\$36,730	\$146,920	\$12,243
8	\$40,890	\$163,560	\$13,630
For each additional person, add \$4,160		\$16,640	\$1,387
Source: U.S. Department of Health and Human Services			

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 counselor

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.

For a list of sample devices provided through iCanConnect, visit www.iCanConnect.org and click on the Equipment Tab.

Application Section 2 of 3: Applicant's Personal Data

(Please fill in all fields)

Name: _____

Address: _____

City: _____, Virginia ZIP: _____

Phone: _____ Voice _____ TTY _____ VP _____

Email: _____

Cell Phone #: _____ Mobile Provider: _____

Contact/Communication Preference: _____

Date of birth: _____ Gender: _____

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

Language preference: _____

Are you a permanent resident of Virginia? _____

Internet or WiFi Access? _____ Internet Provider: _____

Feedback/suggestions (optional): _____

Alternate Contact (in case of emergency): _____

Phone/Cell/VP _____ *Email:* _____

Notes/Special Circumstances: _____

How did you hear about this program?

- | | |
|---|--|
| <input type="checkbox"/> Virginia iCanConnect website | <input type="checkbox"/> National iCanConnect website |
| <input type="checkbox"/> Education provider/school | <input type="checkbox"/> Family member |
| <input type="checkbox"/> Friend | <input type="checkbox"/> Healthcare provider |
| <input type="checkbox"/> Helen Keller National Center | <input type="checkbox"/> Independent Living Center |
| <input type="checkbox"/> Interpreter | <input type="checkbox"/> Media/news |
| <input type="checkbox"/> Senior Center | <input type="checkbox"/> VDDHH Outreach Specialist |
| <input type="checkbox"/> DBVI Deaf-Blind Specialist | <input type="checkbox"/> Virginia Deaf-Blind Project |
| <input type="checkbox"/> Technology vendor | <input type="checkbox"/> DARS Vocational Rehab Counselor |
| <input type="checkbox"/> Disability advocacy group | <input type="checkbox"/> Other _____ |

Income eligibility

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)
- 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 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:** _____



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:

Name of Applicant: _____

Street Address: _____ **City/State/Zip:** _____

Attester Information:

Name of Attester: _____ **Title:** _____

Agency/Employer: _____

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

Street Address: _____ **City/State/Zip:** _____

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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.

I certify under penalty of perjury that, to the best of my knowledge, this individual is deaf-blind as defined by the FCC as above (and as previously referenced in Section 1):

Signature: _____ **Date:** _____

Mail, e-mail, or fax completed application (Sections 1, 2 and 3) to:

**Virginia Department for the Blind and Vision Impaired
Deaf Blind Services - iCanConnect
397 Azalea Avenue, Richmond, VA 23227-3623**

**Telephone inquiries: 1-800-622-2155 or 1-804-371-3140
FAX: 1-804-371-3073**

If scanned documents are submitted, please use PDF format.
This document is available upon request in hard copy print, Braille, and electronic text, or on-line from the www.icanconnect.org/howtoparticipate/virginia website.