



Deaf-Blind Equipment Distribution Program

Application Form

Return Application To:	800.639.3884 (V/TTY)	Email Questions To:
1 Mackworth Island, Bldg. C	207.766.7111 (Videophone)	smurray@drme.org
Falmouth, ME 04105	207.797.9791 (Fax)	www.drme.org

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 total family/household income must be below 400% of the Federal Poverty Guidelines, as shown in the following table:

HOUSEHOLD SIZE	INCOME
1	\$51,040
2	\$68,960
3	\$86,880
4	\$104,800
5	\$122,720
6	\$164,640
7	\$158,560
8	\$176,480
For each additional person, add	\$17,920

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 64.6203(c) states that an individual who is “deaf-blind” is:

- (1) Any individual:
 - (i) 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;
 - (ii) 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
 - (iii) For whom the combination of impairments described in . . . (i) and (ii) of this section cause extreme difficulty in attaining independence in daily life activities, achieving psychosocial adjustment, or obtaining a vocation.
- (2) An individual’s functional abilities with respect to using Telecommunications service, Internet access service, and advanced communications services, including interexchange services and advanced telecommunications and information services in various environments shall be considered when determining whether the individual is deaf-blind under . . . (ii) and (iii) of this section.
- (3) The definition in this paragraph (c) 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.

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 / AT 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 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

Disability Rights Maine (DRM) is committed to ensuring that your privacy is protected. Information provided on this application form will only be used to determine eligibility for NDBEDP products and services. DRM will not sell, distribute or lease your personal information to third parties unless you give permission, or if we are required by law to do so. We are 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 we collect.

APPLICATION SECTION 2 OF 3: APPLICANT'S PERSONAL DATA

(Please Provide all Information - Incomplete Applications Will Be Delayed)

Name of Applicant: _____

Date of Birth: _____ Gender: _____

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

Street Address: _____

City: _____ State: _____ Zip Code: _____

Primary Phone: _____ Voice TTY VP

Alternate Phone: _____ E-mail: _____

State in which you are a permanent resident? _____

Have you participated in iCanConnect (the National Deaf-Blind Equipment Distribution Program) before? Yes – If so, in what state/states (list all): _____ No

Did you previously receive equipment through iCanConnect in another state? Yes – If so, in what state/states (list all): _____ No

Language Preference (check all that apply):

- | | |
|---|--|
| <input type="checkbox"/> ASL | <input type="checkbox"/> Pidgin Signed English |
| <input type="checkbox"/> Close Vision ASL/PSE | <input type="checkbox"/> Signed English |
| <input type="checkbox"/> Tactile ASL/PSE | <input type="checkbox"/> Spanish (spoken) |
| <input type="checkbox"/> English (spoken) | <input type="checkbox"/> Other: _____ |
| <input type="checkbox"/> No Formal Language | |

Which format do you prefer for written correspondence?

- | | |
|--------------------------------------|---|
| <input type="checkbox"/> Braille | <input type="checkbox"/> Standard Print |
| <input type="checkbox"/> E-mail | <input type="checkbox"/> Other: _____ |
| <input type="checkbox"/> Large Print | |

Contact By:

- | | |
|--|---|
| <input type="checkbox"/> E-mail | <input type="checkbox"/> Text Message |
| <input type="checkbox"/> Fax | <input type="checkbox"/> TTY (Relay - Dial 711) |
| <input type="checkbox"/> Phone (Voice) | <input type="checkbox"/> Video Phone |

Alternate Contact (in case of emergency): _____

Relationship with Applicant: _____

Street Address: _____

City: _____ State: _____ Zip Code: _____

Primary Phone: _____ E-mail: _____

Feedback/Suggestions (optional): _____

How did you hear about this program?

- | | |
|--|--|
| <input type="checkbox"/> iCanConnect.org Website | <input type="checkbox"/> Independent Living Center |
| <input type="checkbox"/> Conference or Seminar | <input type="checkbox"/> Interpreter |
| <input type="checkbox"/> Disability Advocacy Group | <input type="checkbox"/> News / Media (TV, Magazine, Radio) |
| <input type="checkbox"/> Specialist in Deaf-Blind Services | <input type="checkbox"/> Social Media (Facebook, Twitter) |
| <input type="checkbox"/> Education Provider / School | <input type="checkbox"/> State Deaf-Blind Project |
| <input type="checkbox"/> Family Members | <input type="checkbox"/> Senior Center |
| <input type="checkbox"/> Friends | <input type="checkbox"/> Technology Vendor |
| <input type="checkbox"/> Healthcare Provider | <input type="checkbox"/> Vocational Rehabilitation Counselor |
| <input type="checkbox"/> HKNC Representative | <input type="checkbox"/> Other: |

Do you wish to be added to Disability Rights Maine’s electronic mailing list?

- ☆ Please make sure we have your email address.
- ☆ By selecting “Yes” you will also be added to DRM Deaf Services’ E-events list.

Yes Yes, but I do not wish to receive E-vent notices No

FOR DRM USE ONLY

Completed Proof of DA Date of Birth Proof of Income Signature

Income Eligibility

To confirm your income eligibility, please mail or fax documentation that proves you are currently enrolled in a federal program with an income eligibility requirement that does not exceed 400% of the Federal Poverty Guidelines, such as the following (refer to next page):

- ✓ Medicaid
- ✓ Supplemental Security Income (SSI)
- ✓ Federal public housing assistance or Section 8
- ✓ Food Stamps or Supplement Nutrition Assistance Program (SNAP)
- ✓ Veterans and Survivors Pension Benefit

If none of the above applies, 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 total family/household income, such as recent Social Security Administration retirement benefit statement(s) or other pension benefit statement(s). Include a signed statement that attests that what you are submitting represents your total family/household income. Note: income eligibility is valid for one year.

I certify that all information provided on this application, including information about my disability and income, is true, complete, and accurate to the best of my knowledge. I authorize program representatives to verify the information provided.

I permit information about me to be shared with my state's current and successor program managers and representatives for the administration of the program and for the delivery of equipment and services to me. I also permit information about me to be reported to the Federal Communications Commission for the administration, operation, and oversight of the program.

If I am accepted into the program, I agree to use program services solely for the purposes intended. I understand that I may not sell, give, or lend to another person any equipment provided to me by the program.

If I provide any false records or fail to comply with these or other requirements or conditions of the program, program officials may end services to me immediately. Also, if I violate these or other requirements or conditions of the program on purpose, program officials may take legal action against me.

I certify that I have read, understand, and accept these conditions to participate in iCanConnect (the National Deaf-Blind Equipment Distribution Program).

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 Code:** _____

Attester Information:

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

Agency/Employer: _____

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

Street Address: _____

City: _____ **State:** _____ **Zip Code:** _____

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

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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).

My attestation is based on the following: _____

Attester Signature: _____

Date: _____

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

Scott Murray
Disability Rights Maine
1 Mackworth Island
Falmouth, ME 04105

smurray@drme.org
Phone: 207.797.7656 • Fax: 207.797.9791

If scanned documents are submitted, please use PDF format.

(This document is available upon request in hard copy print, braille, and electronic text.)

Privacy Statement

The Federal Communications Commission (FCC) collects personal information about individuals through the National Deaf-Blind Equipment Distribution Program (NDBEDP), a program also known as iCanConnect. The FCC will use this information to administer and manage the NDBEDP.

Personal information is provided voluntarily by individuals who request equipment (NDBEDP applicants) and individuals who attest to the disability of NDBEDP applicants. This information is needed to determine whether an applicant is eligible to participate in the NDBEDP. In addition, personal information is provided voluntarily by individuals who file NDBEDP-related complaints with the FCC on behalf of themselves or others. When this information is not provided, it may be impossible to resolve the complaints. Finally, each state's NDBEDP-certified equipment distribution program must submit to the FCC certain personal information that it obtained through its NDBEDP activities. This information is required to maintain each state's certification to participate in this program.

The FCC is authorized to collect the personal information that is requested through the NDBEDP under sections 1, 4, and 719 of the Communications Act of 1934, as amended; 47 U.S.C. 151, 154, and 620.

The FCC may disclose the information collected through the NDBEDP as permitted under the Privacy Act and as described in the FCC's Privacy Act System of Records Notice at 77 FR 2721 (Jan. 19, 2012), FCC/CGB-3, "National Deaf-Blind Equipment Distribution Program (NDBEDP)," <https://www.fcc.gov/omd/privacyact/documents/records/FCC-CGB-3.pdf>.

This statement is required by the Privacy Act of 1974, Public Law 93-579, 5 U.S.C. 552a(e)(3).