



The National Deaf-Blind Equipment Distribution Program

2021 CONSUMER APPLICATION

- First Time Applying
- Returning Consumer
- Other State Recipient
State: _____

Applicant Name: _____

DOB: _____

Address: _____

City: _____

Zip Code: _____

Primary Contact Number: _____ Home Cell

This is a: Voice VP Text TTY

Secondary Contact Number: _____ Home Cell

This is a: Voice VP Text TTY

E-mail: _____

Preferred Contact if you cannot be reached:

NAME

PHONE #

I give permission for iCC Representative to contact this person

TELL US ABOUT YOURSELF

I am: Student Employed Unemployed Retired

My preferred ways to communicate are (please check all that apply):

- American Sign Language
 - Visual
 - Tactile
 - Close Vision
 - Signed English
- Spoken English

If applicable, name/number preferred Interpreter: _____

My preferred way to read is:

- Print
- Large Print
- Braille
- Listening

My preferred method of communication is:

- Orally by phone
- Visually through ASL Interpreter
- Text by email or messenger application
- Video platform with captioning
- Other: _____

**ELIGIBILITY REQUIREMENT 1
FINANCIAL VERIFICATION**

Please check one of the following requirements and provide support documentation to verify your income eligibility: To be eligible for this federally funded program, your household income cannot exceed 400% of the federal poverty guidelines or you must qualify for the following programs:

- I am eligible for the following program and will provide documentation of:
 - Federal Public Housing Assistance (Section 8)
 - Medicaid
 - Low-Income Energy Assistance Program/Pharmaceutical Assistance for the Aged and Disabled
 - Temporary Assistance for Needy Families
 - Supplemental Nutrition Assistance Program (Food Stamps)/PAAD
 - SSI (Supplemental Security Income)
 - SSDI (Social Security Disability Insurance)

**SSI/SSDI ONLY: Include letter stating this is your only source of income or include additional income sources*

I DO NOT qualify for any of the programs listed above and will provide the following:

- How many people live in your household? _____
- Federal Income Tax Return (full return required)

The 2021 income guidelines are listed below:

2021 Federal Poverty Guidelines	
Number of persons in family/household	400% for everywhere, except Alaska and Hawaii
1	\$51,520
2	\$69,680
3	\$87,840
4	\$106,000
5	\$124,160
For each additional person, add	\$18,160
Source	U.S. Department of Health and Human Services

**ELIGIBILITY REQUIREMENT 2
DISABILITY VERIFICATION**

For this program, the FCC 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. Please share the following information to assist the program to determine your eligibility.

- Yes- I have a hearing loss, the cause of my hearing loss is:
 - Born deaf
 - Lost hearing as a result of: _____
- I have:
 - Hearing Aids
 - Bone Conductive Hearing System
 - Cochlear Implant(s)
 - None of the above
- Yes- I am blind or visually impaired, the cause of my vision loss is:
 - Born Blind
 - Lost vision as a result of: _____
- Yes- I have a progressive condition that results in combined hearing and vision loss called:

I DO NOT know if my hearing and vision loss are related

I am/or have been a client of NJ CBVI: Yes No Unsure
Department: Vocational Rehabilitation Independent Living Education

If yes, who is your primary contact: _____

Are you receiving services from a vision loss, hearing loss or deaf-blind professional?
Program/Contact person/Contact Information:

Do you receive SSP Services? Yes No
 I DO NOT know what SSP means and would like more information.

I am providing the following documentation to verify my disability eligibility:

- An IEP with the classification of Deaf-Blindness**
- Copy of most recent Audiological Report**
- Copy of most recent Vision Report**
- Copy of confirmed diagnosis resulting in Deaf-Blindness**
- Provided Disability Attestation Document from a professional who has direct knowledge of my combined hearing and vision loss.**

TELL US ABOUT YOUR CURRENT COMMUNICATIONS TECHNOLOGY EXPERIENCE

1. How do you make phone calls? **(Check all that apply)**

- Home phone
- Captel device
- Mobile phone provider: _____
- Smart phone
- Relay service
- Facetime
- Other: _____
- Do not have access to making phone calls at this time
- Check here if any these devices were provided through the iCC Program**

2. What device(s) and programs are you currently using?

(Check all that apply)

- Desktop
- Laptop
- iPad/Tablet
- JAWS
- Zoomtext
- Alerting Devices
- Check here if these devices were provided through the iCC Program**

3. In the last five years have you had computer training? Yes No

If yes, where did this training take place? **(Check all that apply)**

- iCanConnect
- One on one training through another program
- Public class
- Store (ex: apple/verizon)
- Family/Friend taught me

4. What is it that you can't do now that you would like to do? **(Check all that apply)**

- Have access to accessible equipment
- Learn about newer technology available
- Be able to communicate with family and friends
- Have access to email
- Be alerted when I have incoming calls/messages

5. I have access to the following platforms:

- Zoom
- Google Meet
- Google Messenger
- Google Drive
- None of the above

Release of Information

I authorize the New Jersey Commission for the Blind and Visually Impaired and The College of Jersey to share information regarding my application, assessment, and telecommunications needs.

I also give them permission to communicate with any individual(s) and/or professional(s) listed in this application.

I also give them permission to communicate with other state iCanConnect Programs

Applicant Name

Signature

Date

If applicant is under 18 years of age:

Name of applicant

Printed name of person signing on behalf of applicant

Relationship to applicant

Signature

Date

Request for iCanConnect/NJ Services

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).

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.

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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).

Applicant Signature _____ **Date** _____

If applicant is under 18 years of age

Name of applicant

Printed name of person signing on behalf of applicant/

Relationship to applicant

Signature

Date

RETURN THIS COMPLETED FORM TO

Did you include:

- Signed Release of Information and Application
- Provide support documentation for hearing/vision loss
- Provide support documentation for income verification

*We cannot determine eligibility if we do not receive all three of these items

Carly Fredericks
The College of New Jersey
PO Box 7718
Ewing, New Jersey 08628

E-mail: carly.fredericks@tcnj.edu • Telephone: (609)771-2711 • Fax: (609)637-5144

If scanned documents are submitted, please use PDF format.



STATE OF NEW JERSEY
DEPARTMENT OF HUMAN SERVICES
COMMISSION FOR THE BLIND AND VISUALLY IMPAIRED



THE COLLEGE OF NEW JERSEY
CENTER FOR SENSORY AND
COMPLEX DISABILITIES