

**National Deaf-Blind Equipment Distribution Program**

California State Information and Application

**Overview**

The National DeafBlind 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 DeafBlind 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:

|  |
| --- |
| 2023 Federal Poverty Guidelines |
| Number of persons in family/household | 400% for everywhere, except Alaska and Hawaii | 400% for Alaska | 400% for Hawaii |
| 1 |  $58,320  |  $72,840  |  $67,080  |
| 2 |  $78,880  |  $98,560  |  $90,720  |
| 3 |  $99,440  |  $124,280  |  $114,360  |
| 4 |  $120,000  |  $150,000  |  $138,000  |
| 5 |  $140,560  |  $175,720  |  $161,640  |
| 6 |  $161,120  |  $201,440  |  $185,280  |
| 7 |  $181,680  |  $227,160  |  $208,920  |
| 8 |  $202,240  |  $252,880  |  $232,560  |
| For each additional person, add | $20,560 | $25,720 | $23,640 |
| Source: [U.S. Department of Health and Human Services](https://aspe.hhs.gov/poverty-guidelines)  |

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

“Income” is all income 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: either 1) proof of your current participation in a federal low-income program whose income limit is below 400% of the Federal Poverty Guidelines, or 2) proof of household income.

**Disability eligibility**

For this program, the CVAA requires that the term "DeafBlind" 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 “DeafBlind” 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 DeafBlind 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
* Vision professional (MD, OD)
* Speech pathologist
* Hearing professional
* HKNC representative
* Medical/health professional
* School for the deaf and/or blind
* Specialist in Deaf-Blindness
* CTAP Certifier
* Vocational Rehabilitation Specialist

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**

NDBEDP 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. NDBEDP will not sell, distribute, or lease your personal information to third parties unless you give permission, or if the NDBEDP program is required by law to do so. NDBEDP 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 NDBEDP collects.



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California State Information and Application

**Application Section 1 of 6: Personal Information**

**Name of Applicant:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Date of birth:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Gender:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Home Address:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**City/State/Zip Code:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Mailing Address (if different):** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**City/State/Zip Code:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Primary** **Phone:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ ☐ Voice ☐ TTY ☐ VP

**Alternate Phone:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Email:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Best times to contact:** Morning / Afternoon / Evening / Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Ethnicity:** This section is *optional* and requested only for data collection purposes.

☐ Caucasian ☐ Latino/Hispanic

☐ African American ☐ Asian

☐ Eastern European/Russian ☐ Native American or Alaskan Native

☐ Native Hawaiian or Pacific Islander ☐ Middle Eastern

☐ Other: \_\_\_\_\_\_\_\_\_\_

**All Annual Income:** $\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**How many people are living in your household?** \_\_\_\_\_\_\_\_

**To confirm your income eligibility, you must also attach documentation that proves one of the following:**

1. 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:
	1. Medicaid
	2. Supplemental Security Income (SSI)
	3. Federal public housing assistance or Section 8
	4. Food Stamps or Supplemental Nutrition Assistance Program (SNAP)
	5. Veterans and Survivors Pension Benefit; OR
2. Proof of all household income (as described in Section 1)

Please 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).

**Alternate Contact Person (for Applicant)**

**Name:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Relationship:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Telephone Number:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ ☐ VP ☐ Voice

**Email address:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Application Section 2 of 6: Profile**

**Hearing Level:**

☐ Deaf ☐ Hard-of-hearing

☐ Late deafened ☐ Can understand speech

Cause of Deafness/Hearing Disability:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**Vision Level:**

☐ Blind ☐ Low Vision

Cause of Blindness/Low Vision:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**Language preference** *(check all that apply):*

☐ ASL ☐ Close Vision ASL/PSE

☐ Tactile ASL/PSE ☐ English (spoken)

☐ No Formal Language ☐ Pidgin Signed English

☐ Signed English ☐ Spanish (spoken)

☐ Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Application Section 3 of 6: Communication Methods**

**Which of these activities do you currently perform**? Check all that apply.

☐ Braille (reading and writing) ☐ Text messaging

☐ Text Relay calls by landline ☐ Instant messaging

☐ Text Relay calls by web/computer ☐ Email

☐ Phone w/ amplification ☐ Video Relay calls by landline

☐ Video calls by web/computer ☐ Videophone

☐ Phone w/ amplification & large print ☐ Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**What equipment do you use to perform the above tasks?** Check all that apply.

☐ TTY ☐ iPad or other tablet device

☐ Video equipment / phone ☐ iPhone or other smart phone

☐ Computer with braille display ☐ CA Telephone Access Phone

☐ Computer with screen magnification ☐ CapTel (Caption to Telephone)

☐ Computer with speech screen reader ☐ Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Do you have internet connection in your home you can use?**  ☐ Yes ☐ No

**Do you currently have a wireless/data plan?** ☐ Yes ☐ No / Company: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Application Section 4 of 6: Specific Equipment Request**

If you know what telecommunication devices will meet your needs, please provide **DETAILED** information in the space below. Indicate the need for training (yes or no). All requests will be taken into consideration during assessment based on current program guidelines. Do *not* complete this section if you do not know what you need.

**Equipment Name:**

**Brand (Manufacturer):**

**Function:**

**Training needed:** Yes / No

**Equipment Name:**

**Brand (Manufacturer):**

**Function:**

**Training needed:** Yes / No

**Equipment Name:**

**Brand (Manufacturer):**

**Function:**

**Training needed:** Yes / No

**Application Section 5 of 6: Applicant Signature**

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 the National Deaf-Blind Equipment Distribution Program (NDBEDP).

**Name of applicant:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Signature:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Date:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

If this application is completed by someone other than the applicant, please fill out the following information.

**Name:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_

**Relationship:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Telephone:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ ☐ Voice ☐ VP ☐ TTY ☐ Fax

**Email Address:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Signature:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Date:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

*By affixing my name above, I certify that I am signing this application for the applicant and with the applicant’s knowledge and consent. I agree to take full responsibility for the care and use of any telecommunication equipment received by and on behalf of \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (applicant’s name). I will ensure the equipment will be used only by the applicant for the expressed purposes of telecommunication activities.*



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**Application Section 6 of 6: Disability Verification**

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

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

**Name of Attester:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Title:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Professional information:**

☐ Doctor/RN ☐ Ophthalmologist/OD ☐ DeafBlind Specialist

☐ Audiologist ☐ Low vision specialist ☐ DOR Counselor (QRP)

☐ Speech therapist ☐ Community agency specialist ☐ Occupational Therapist

☐ Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**License/Certificate Number:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Mailing Address:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**City/State/Zip Code:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**E-mail:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Phone:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

For this program, the CVAA requires that the term "DeafBlind" 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 applicant's functional abilities with respect to 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.

**My attestation is based on the following:**

(*Please state how you are familiar with each of the applicant's hearing and vision loss, AND the applicant’s combination of hearing and vision loss, as defined in the FCC’s NDBEDP rules listed directly above):*

**Vision loss:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**Hearing loss:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**Describe how the combination of hearing and vision loss affects this person in daily life** (Please refer to the definition of deaf-blind in this section of the application**):**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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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).

**Attester Signature:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Date:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Mail, e-mail, or fax completed application to:**

LightHouse for the Blind and Visually Impaired

Attn: DeafBlind Services

3075 Adeline Street, #110

Berkeley, CA 94703

English/Spanish: Jeffrey Colon • fcc@lighthouse-sf.org • Voice: (415) 694-7368

American Sign Language: Nai Damato • fcc@lighthouse-sf.org • Voice/VRS/Text: 415-694-7316

**Before Sending Application, have you included:**

☐ Proof of Income

☐ Proof of Hearing Disability

☐ Proof of Legal Blindness

**Privacy Statement**

The Federal Communications Commission (FCC) collects personal information about individuals through the National DeafBlind 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 DeafBlind 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).