2024 CONSUMER APPLICATION

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

Applicant Legal Name: _____

Date Birth: _____

Address: _____

City, State, Zip Code: _____

Primary Contact Number: _____

Gender

Preferred Name

E-mail: _____

☐ Do not have access to email at this time

Preferred Contact if you cannot be reached:

NAME	EMAIL	PHONE #	RELATION

☐ I give permission for the iCC Representative to contact this person and share information regarding my application and status

TELL US ABOUT YOURSELF

I am:

- ☐ Student
- ☐ Employed
- ☐ Unemployed
- ☐ Retired

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

- ☐ Spoken English
- ☐ Visual American Sign Language
- ☐ Tactile Sign Language
- ☐ Close Vision
- ☐ Signed 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: _____

I would like my Remote Intake Meeting to be held by:

- ☐ Orally by phone
- ☐ Video phone conference through ASL interpreter
- ☐ Zoom Platform with Visual ASL Interpreter
- ☐ Zoom Platform with Captions

Please expand on any of your current technology needs for distant communication and share any additional information that would help us enhance your experience with the program:

ELIGIBILITY REQUIREMENT 1
FINANCIAL VERIFICATION

Please check one of the following requirements and support documents 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? _____

☐ 2023 Federal Income Tax Return will be submitted (full return required)

The 2024 income guidelines are listed below:

2024 Federal Poverty Guidelines	
Number of persons in family/household	**400% for everywhere, except Alaska and Hawaii**
1	**$60,240**
2	**$81,760**
3	**$103,280**
4	**$124,800**
5	**$146,320**
For each additional person, add	**$21,520**
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
- ☐ Cellular Provider: _____
- ☐ Smart Phone
- ☐ Relay Service
- ☐ Facetime
- ☐ Other: _____
- ☐ Do NOT have access to making 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
- ☐ iCanConnect Provided
- ☐ Yes-I have received training in the last 3 years
- ☐ No-I have not received any training

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

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

6. Please share your priority needs for distant communication:

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**

How did you learn about this program?

- ☐ Referred by my CBVI counselor
- ☐ Referred by a representative from HKNC
- ☐ iCanConnect National Website
- ☐ Social Media Platform/Advertisement
- ☐ Local NJ Agency:
- ☐ Program recipient, family member, or friend
- ☐ Community Event:

Request for iCanConnect/NJ Services

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

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 move and apply to any other state iCanConnect program, I also permit all state iCanConnect program(s) I participated in to send my program records to any other state iCanConnect program I apply to.

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).

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.

☐ ***Read Privacy Statement***

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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).

_____

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 the following:

- ☐ **Signed Release of Information and Application**
- ☐ **Support documentation for combined hearing and vision loss disability verification**
- ☐ **Support documentation for income verification**

***Eligibility cannot be determined if we do not receive all three of these items**

The College of New Jersey
PO Box 7718
Attention: iCanConnect Program
Ewing, New Jersey 08628
E-mail: iCanConnect@tcnj.edu • Telephone: (609)771-2711• Fax: (609)637-5144

If scanned documents are submitted, please use PDF format.

NJCBVI
NEW JERSEY COMMISSION FOR THE BLIND AND VISUALLY IMPAIRED

THE COLLEGE OF NEW JERSEY
CENTER FOR SENSORY AND COMPLEX DISABILITIES