akCanConnect

Alaska's Deaf-Blind Equipment Distribution Program

Today's Date:____________ Specialist:____________ AGR #:____________

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 www.atlaak.org/programs/akcanconnect

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.

All applicants must provide the required verification of their status as low-income and deaf-blind prior to being scheduled for a communication assessment to determine possible telecommunication equipment.

Income Eligibility

To be eligible, your family/household income must be below 400% of the poverty level or proof of household income:

2024 Federal Poverty Guidelines

Number of persons in family/household	400% for Alaska
1	$75,240
2	$102,160
3	$129,080
4	$156,000
5	$182,920
6	$209,840
7	$236,760
8	$263,680
For each additional person, add	$26,920
Source: U.S. Department of Health and Human Services	

See Part 3 of Section 2 for the family/household information that must be provided.

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 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 "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/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 Social Security determination letter, may serve as verification of disability.

See Section 3 for the disability attestation information that must be provided with the application.

Confidentiality Policy

akCanConnect is committed to ensuring that your privacy is protected. Information provided on this application form will only be used to determine eligibility for akCanConnect products and services. akCanConnect will not sell, distribute or lease your personal information to third parties unless you give permission, or if the akCanConnect program is required by law to do so. akCanConnect 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 akCanConnect collects.

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).

Section 2 of 3: Application

First Name:____________________ Last Name:____________________

Mailing Address:____

City:____________________ State:____________ Zip:__________

How many members are in your household?____________________

Home #:______________ ☐ Voice ☐ TTY ☐ VP Cell #:______________

Email:______________ Gender: ☐ M ☐ F DOB:______________

Communication Preference:

☐ TTY ☐ VP ☐ CapTel ☐ Cell ☐ TRS ☐ VRS ☐ Email ☐ Fax

Written Correspondence Preference:

☐ Braille ☐ Email ☐ Standard Print ☐ Large Print ☐ Other:______________

Language Preference:

☐ English (spoken)
☐ Spanish (spoken)
☐ No formal language
☐ Tactile Signing
☐ Close Vision Signing
☐ Signed English
☐ American Sign Language
☐ Pidgin Signed English
☐ Other:____

How did you hear about this program?

☐ ATLA website
☐ Disability advocacy group
☐ Education provider/school
☐ Healthcare provider
☐ Helen Keller National Center (HKNC) representative
☐ Independent Living/Senior Center
☐ Interpreter
☐ Media/news
☐ Specialist in Deaf-Blind Services
☐ State Deaf-Blind Project
☐ Vocational Rehabilitation
☐ Other:____

Alternate Contact

First Name:____________________ Last Name:____________________

Mailing Address:____

City:____________________ State:____________ Zip:__________

Home #:______________ ☐ Voice ☐ TTY ☐ VP Email:______________

Communication Preference:

☐ TTY ☐ VP ☐ CapTel ☐ Cell ☐ TRS ☐ VRS ☐ Email ☐ Fax

Disability Verification

1) Do you have a visual acuity of 20/200 or less?

   ☐ Yes ☐ No If "yes," what is it?______________________________

   If "NO" do you have a reasonable expectation that this applicant will progressively reach a visual acuity loss of 20/200?

   ☐ Yes ☐ No

2) Do you have field restriction such that the peripheral diameter of visual field subtends an angular distance no greater than 20 degrees?

   ☐ Yes ☐ No If "yes," what is it?______________________________

   Do you have a reasonable expectation that this applicant has a prognosis that will lead to this condition?

   ☐ Yes ☐ No

3) Do you have a chronic hearing impairment, that most speech is not understood with optimum amplification?

   ☐ Yes ☐ No

   If "NO" do you have a reasonable expectation that this applicants hearing will progress to the point that speech is not understood with optimum amplification?

   ☐ Yes ☐ No

4) Does the combination of conditions listed in 1&2 cause difficulty with independence in daily living, psychosocial adjustment, or obtaining a vocation?

   ☐ Yes ☐ No

5) Have you been served through the National Deaf-Blind Equipment Distribution Program in another state?

   ☐ Yes ☐ No If "yes," where?______________________________

Notes

Income Eligibility

To confirm your income eligibility, please mail or fax documentation that proves your eligibility for one of the following federal programs:

- ☐ Federal public housing assistance or Section 8
- ☐ Food Stamps or Supplement Nutrition Assistance Program (SNAP)
- ☐ Low-income home energy assistance
- ☐ Medicaid
- ☐ National School Lunch Program's free lunch program
- ☐ Supplemental Security Income (SSI)
- ☐ Temporary Assistance for Needy Families (TANF) or Welfare to Work (WTW)
- ☐ Veterans and Survivors Pension Benefit

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). If you send other evidence of your family/household income, include a signed statement that attests that what you are submitting is your only source of income.

Applicant Attestation (Signature Required)

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:**____________________

Section 3 of 3: Disability Attestation/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:

First Name:____________________________ Last Name:____________________________

Mailing Address:____

City:______________________________ State:__________________ Zip:____________

Attester Information:

Name of Attester:________________________ Last Name:____________________________

Agency/Employer:____

Mailing Address:____

City:______________________________ State:__________________ Zip:____________

Contact #:____________________ ☐ Voice ☐ TTY ☐ VP Email:_______________________

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    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.
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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:
(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:____

____

Hearing Loss:_______________________________________

____

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)

____

____

Attester Signature:_________________________ **Date:**____________________

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

Mail, e-mail, or fax completed form to the following:

E-mail: atla@atlaak.org
Fax: 907-563-0699
Phone: 907-563-2599

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AkCanConnect Program
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