



1187 Alturas Drive  
Moscow, Idaho 83843  
1-800-432-8324

idahoat@uidaho.edu  
idahoat.org

## 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 [icanconnect.org](http://icanconnect.org) or [fcc.gov/ndbedp](http://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:

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
6	\$167,840
7	\$189,360
8	\$210,880
For each additional person, add	\$21,520

Source: [US 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 the Application & Financial Eligibility Form 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 “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
- DeafBlindness specialist
- 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 the Disability Verification Form for the disability attestation information that must be provided with this application.

## **Confidentiality Policy**

iCanConnect is committed to ensuring that your privacy is protected. Information provided on this application form will only be used to determine eligibility for iCanConnect products and services. iCanConnect will not sell, distribute or lease your personal information to third parties unless you give permission, or if the iCanConnect program is required by law to do so. iCanConnect 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 iCanConnect 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)," [fcc.gov/omd/privacyact/documents/records/FCC-CGB-3.pdf](http://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).



## Application and Financial Eligibility

Please fill in all fields. If you are under age 18, your parent or legal guardian must sign the application.

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

Date of birth: \_\_\_\_\_

Gender: \_\_\_\_\_

Ethnicity: \_\_\_\_\_ Hispanic or Latino? \_\_\_\_\_

Street address: \_\_\_\_\_

City: \_\_\_\_\_

State: \_\_\_\_\_ Zip code: \_\_\_\_\_

Primary phone: \_\_\_\_\_

Voice \_\_\_\_\_ TTY \_\_\_\_\_ VP \_\_\_\_\_ Text message \_\_\_\_\_

Alternate phone: \_\_\_\_\_

Email: \_\_\_\_\_

State in which you are a permanent resident? \_\_\_\_\_

Have you participated in iCanConnect (the National Deaf-Blind Equipment Distribution Program) before (check yes or no)?

\_\_\_\_\_ Yes

\_\_\_\_\_ No

If yes, list the state/states you participated in iCanConnect:

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Did you previously receive equipment through iCanConnect in another state (check yes or no)?

\_\_\_\_\_ Yes

\_\_\_\_\_ No

If yes, list the state/states you received equipment through iCanConnect:

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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: \_\_\_\_\_

Which format do you prefer for written correspondence?

\_\_\_\_\_ Braille

\_\_\_\_\_ Email

\_\_\_\_\_ Large print

\_\_\_\_\_ Standard print

\_\_\_\_\_ Text message

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

Contact by:

\_\_\_\_\_ Email

\_\_\_\_\_ Fax

\_\_\_\_\_ Text Message

\_\_\_\_\_ TTY (dial 711 for Relay)

\_\_\_\_\_ Video Phone

\_\_\_\_\_ Phone (voice)

Alternate contact (in case of emergency): \_\_\_\_\_

Relationship with applicant: \_\_\_\_\_

Street address: \_\_\_\_\_

City: \_\_\_\_\_

State: \_\_\_\_\_ Zip code: \_\_\_\_\_

Primary phone: \_\_\_\_\_

Email: \_\_\_\_\_

How did you hear about this program?

- ☐ iCanConnect.org website
- ☐ Conference or seminar
- ☐ Disability advocacy group
- ☐ Specialist in deaf-blind services
- ☐ Education provider/school
- ☐ Family members
- ☐ Friends
- ☐ Healthcare provider
- ☐ Helen Keller National Center (HKNC) representative
- ☐ Independent living center
- ☐ Interpreter
- ☐ News/media (television, magazine, radio)
- ☐ Social media (Facebook, Twitter)
- ☐ State deaf-blind project
- ☐ Senior center
- ☐ Technology vendor
- ☐ Vocational rehabilitation counselor
- ☐ Other: \_\_\_\_\_

## Income Eligibility

Number of people in household: \_\_\_\_\_

Gross monthly household income: \_\_\_\_\_

Please check if you receive government assistance under any of the programs below and include a copy that documents your eligibility for the current year.

- ☐ Medicaid
- ☐ Supplemental Security Income (SSI)
- ☐ Federal public housing assistance or Section 8
- ☐ Food Stamps or Supplemental Nutrition Assistance Program (SNAP)
- ☐ National School Lunch Program
- ☐ Temporary Assistance for Needy Families
- ☐ Veterans and Survivors Pension Benefit

Or, please include 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 pay stubs, recent Social Security Administration benefit statement(s) or other pension benefit statement(s) to document household 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, iCanConnect programs in others states where I might apply in the future, 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):

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

If this application is completed by someone other than the applicant, please state your name and relationship to the applicant:

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I certify that I am signing this application for the applicant and with the applicant's knowledge and consent.

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



## Disability Verification Definitions

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

## 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).

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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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## Disability Verification

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

### Disability Verification is Provided By:

Name: \_\_\_\_\_ Title: \_\_\_\_\_

Email: \_\_\_\_\_ Phone: \_\_\_\_\_

Agency/Organization: \_\_\_\_\_

Address: \_\_\_\_\_

Please describe your role and experience with this individual to be able to certify their eligibility for this program:

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Qualifying diagnoses: \_\_\_\_\_

#### 1. Vision:

Does this applicant have:

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 of these conditions?

2. Hearing:

Does this applicant have:

- a chronic hearing impairment so severe that most personal or distance conversations cannot be understood with optimum amplification; or,
- a progressive hearing loss having a prognosis leading to this condition?

3. Impact on independence:

Does the combination of vision and hearing loss cause extreme difficulty in attaining independence in daily life activities including communication with someone who is not in the same room, achieving psychosocial adjustment, or obtaining a vocation?

\_\_\_\_\_ Yes

\_\_\_\_\_ No

Please describe how the combination of vision and hearing loss affects this person in activities of daily living, social interactions, working, and ability to use telecommunications, internet, and advanced information systems:

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OR...

4. Functional Performance:

Unable to accurately measure hearing and vision loss due to cognitive or behavioral constraints but functional/performance assessment shows severe hearing and visual disabilities that cause extreme difficulty in attaining independence in daily life activities, achieving psychosocial adjustment, or obtaining vocational objectives. Please attach any additional documentation as needed.

I certify under penalty of perjury that, to the best of my knowledge, this individual is deaf-blind as defined by the FCC on the previous page, as follows (Individual must meet number 1, 2 and 3, or number 4 to qualify for this program).

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

Please return disability verification to:

Krista Kramer, Idaho Assistive Technology Project

1187 Alturas Drive

Moscow, ID 83843

E-mail: [kkramer@uidaho.edu](mailto:kkramer@uidaho.edu)

Telephone: 1-800-432-8324 or 208-885-6097

Fax: 208-885-6102