



**Commonwealth of the Northern Mariana Islands (CNMI)  
iCanConnect  
The National DeafBlind Equipment Distribution Program**

**Section 1: Instructions and Guidelines**

**Overview**

The National DeafBlind Equipment Distribution Program (NDBEDP) supports local programs that distribute equipment to low-income individuals who are DeafBlind (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>.

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**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 DeafBlind.

**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:

**2024 Federal Poverty Guidelines**

- **Number of persons in family/household: 1**
  - **Household income for everywhere, except Alaska and Hawaii: \$60,240**
  - **for Alaska: \$75,240**

- for Hawaii: \$69,240
- Number of persons in family/household: 2
  - Household income for everywhere, except Alaska and Hawaii: \$81,760
  - for Alaska: \$102,160
  - for Hawaii: \$94,000
- Number of persons in family/household: 3
  - Household income for everywhere, except Alaska and Hawaii: \$103,280
  - for Alaska: \$129,080
  - for Hawaii: \$118,760
- Number of persons in family/household: 4
  - Household income for everywhere, except Alaska and Hawaii: \$124,800
  - for Alaska: \$156,000
  - for Hawaii: \$143,520
- Number of persons in family/household: 5
  - Household income for everywhere, except Alaska and Hawaii: \$146,320
  - for Alaska: \$182,920
  - for Hawaii: \$168,280
- Number of persons in family/household: 6
  - Household income for everywhere, except Alaska and Hawaii: \$167,840
  - for Alaska: \$209,840
  - for Hawaii: \$193,040
- Number of persons in family/household: 7
  - Household income for everywhere, except Alaska and Hawaii: \$189,360
  - for Alaska: \$236,760
  - for Hawaii: \$217,800
- Number of persons in family/household: 8
  - Household income for everywhere, except Alaska and Hawaii: \$210,880
  - for Alaska: \$263,680

- for Hawaii: \$242,560
- For each additional person in the household, add
  - for everywhere, except Alaska and Hawaii: \$21,520
  - for Alaska: \$26,920
  - for Hawaii: \$24,760

**Source: U.S. 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 Section 3 for the family/household income information that must be provided with this application.**

**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 (work/employment).**

**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
- Community-based service provider
- Educator
- Hearing professional
- HKNC representative
- Medical/health professional
- School for the deaf and/or blind
- Specialist in DeafBlindness
- 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 DeafBlind, such as an audiogram, vision records, individualized education program (IEP) or a Social Security determination letter, may serve as verification of disability. These items will be requested.**

**See Section 3 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.**



**Commonwealth of the Northern Mariana Islands (CNMI)  
DeafBlind Equipment Distribution Program**

**Section 2: Applicant Information**

**Name of Applicant (first name, middle initial, last name):**

**Home Address:**

**City:**

**State:**

**Zip Code:**

**County:**

**Community/Facility Name (i.e., nursing home, apartment complex):**

**Mailing Address (if different):**

**City:**

**State:**

**Zip Code:**

**Primary Phone**

**(Please place an X next to the choice you are marking):**

**Voice**

**Videophone**

**Text**

**Email Address:**

**Best time to contact:**

**Gender**

**(Please place an X next to the choice you are marking):**

**Male**

**Female**

**Gender Diverse (please write):**

**Date of Birth (MM/DD/YYYY):**

**Do you (the applicant) meet the definition of DeafBlind outlined in Section 1?**

**(Please place an X next to the choice you are marking.)**

**Yes**

**No**

**Cause of Hearing Loss - Describe your hearing loss**

**1. When did your hearing loss begin (at what age)?**

**2. Cause of Deafness/Hearing Loss:**

**(Please place an X next to the choice you are marking):**

**Deaf**

**Hard-of-hearing**

**Late deafened**

**Can understand speech**

**NOT Deaf or Hard-of-hearing**

**Hearing Aids Brand/Type:**

**Cause of Vision Loss – Describe your vision loss:**

**1. When did your vision loss begin (at what age)?**

**2. Cause of Blindness/Low Vision:**

**(Please place an X next to the choice that describes your vision):**

**Blind**

**Low vision**

**NOT Blind or Low Vision**

**Wear glasses?**

**If you have useable vision, please describe:**

**Communication preference**

**(Please place an X next to the choices you are marking):**

**American Sign Language (ASL)**



**Tactile Sign Language**  
**Pidgin Sign Language (PSE)**  
**Close Vision Sign Language**  
**Sign Exact English (SEE)**  
**Spoken Language, if other than English, please specify:**  
**Other (specify):**

**Which of these activities do you currently perform?**  
**(Please place an X next to the choices you are marking.)**

**Braille (reading and writing)**  
**Text messaging**  
**Instant messaging**  
**Email**  
**Telephone with Amplification**  
**Relay calls by landline telephone**  
**Telephone with Amplification & Large Print**  
**Relay calls by web/computer/smartphone**  
**Videophone/Video chat**  
**Other:**

**Do you have an Internet connection in your home that you can use?**

**(Please place an X next to the choice you are marking.)**

**Yes**

**No**

**Internet Provider name:**

**Do you currently have a Cellular Plan?**

**(Please place an X next to the choice you are marking.)**

**Yes**

**No**

**Cellular Company:**

**May we add you to the HKNC National Registry?**

**(Please place an X next to the choice you are marking.)**

**Yes**

**No**

I'm already registered.

State in which you are a permanent resident:

Have you participated in iCanConnect (the National DeafBlind Equipment Distribution Program) (received technology) before?

(Please place an X next to the choice you are marking.)

Yes

No

If yes, what state/states did you participate in iCanConnect/receive technology? (list all):

Alternate/Emergency Contact:

Name:

Relationship with Applicant:

Street Address:

City:

State:

Zip Code:

Primary Phone:

(Please place an X next to the choice you are marking)

Voice

Text

Videophone

Email address:

REQUIRED Financial information:

Number of people living in the home:

Total Household Income: \$

Attach proof of income to THIS Application.

*Review application instructions for examples of proof of income. To be eligible for this program, the applicant's income must meet the requirements located in Section 1.*

### **Income eligibility**

To confirm your income eligibility, please mail or fax documentation that proves 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 the following:

- Medicaid
- Supplemental Security Income (SSI)
- Federal public housing assistance or Section 8
- Food Stamps or Supplement Nutrition Assistance Program (SNAP)
- Veterans and Survivors Pension Benefit

If none of the above applies, 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).

Note: income eligibility is valid for one year.

### **Section 3: Applicant's Attestation regarding Disability and Income Eligibility**

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. 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. 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 DeafBlind Equipment Distribution Program (NDBEDP).

**Applicant's Name (PRINT):**

**Applicant's Signature:**

**Date:**

**Parent or Legal Guardian if \*Applicant is under 18 years of age:**

**Name:**

**Relationship:**

**Phone:**

**(Please place an X next to the choice you are marking)**

**Voice**

**Text**

**Videophone**

**Fax:**

**Email address:**

**Signature Parent/Guardian:**

***“As parent/guardian 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.” \*If the applicant is over age 18, please provide proof of legal guardianship and/or Power of Attorney documentation. If application is completed by someone other than the applicant, please state full name.***

**Name:**

**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.**

#### **Section 4: Professional Certification**

**One healthcare professional must sign the application. By signing below, you certify you have direct knowledge of the applicant’s vision and hearing loss.**

**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;**

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**(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 DeafBlind under . . . (ii) and (iii) of this section.**

**(3) The definition in this paragraph 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.**

**I certify under penalty of perjury that, to the best of my knowledge, this individual is DeafBlind as defined by the FCC as above and as previously referenced in Section 1.**

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.

\*My attestation for each, hearing, vision and combined loss is based on:

Applicant's name:

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 DeafBlind in this section of the application):

Professional information (Please place an X next to the choice you are marking):

Audiologist

Community-based service provider

Educator

Hearing professional

HKNC representative

Medical/health professional

School for the deaf and/or blind

Specialist in DeafBlindness

Speech pathologist

State equipment/assistive technology program

Vision professional

Vocational rehabilitation counselor

Other (please define):

Printed Name:

Title:

**Professional signature:**

**Date:**

**Mailing Address:**

**Email:**

**Telephone:**

**(Please place an X next to the choice you are marking)**

**Voice**

**Text**

**Videophone**

**License/Certificate number:**

### **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).**

**Email completed applications with supporting documents to:**

**Isabel Mejia Ramos  
Helen Keller National Center  
PO Box 4269  
Crestline, CA 92325  
E-mail: imejiaramos@helenkeller.org  
Video phone: (808) 458-5896**