The FCC National Deaf Blind Equipment Distribution Program certifies one agency per state to distribute equipment to eligible individuals who are deaf blind which is a combined hearing and visual loss enable access to telephone, advanced communications, and information services. The Connecticut Tech Act Project Access Through Technology program is Connecticut’s certified entity. This program is also known nationally as “iCanConnect”.:

The goal of the National Deaf-Blind Equipment Distribution Program (NDBEDP) is to ensure that every person with combined hearing and vision loss has access to modern telecommunication tools and the training necessary to use them, granting every individual the opportunity to interact with the world as an involved, contributing member of society.:

This application is open to CT residents that are deaf-blind and meet the income eligibility guidelines. Its purpose is to request assistive technology devices and services to effectively access telecommunication services, internet access services, and advanced communications, including interexchange services and advanced telecommunications.

Where to Send Your Application.

Please return this application via one of the following methods:

Mail: Access through Technology:

55 Farmington Avenue, 12th floor:

Hartford, CT 06105:

ATTN: Muriel C.M. Aparo:

Fax: 860-424-5619:

Email: [muriel.aparo@ct.gov](mailto:muriel.aparo@ct.gov):

In compliance with the Americans with Disabilities Act, this information is available in alternate formats upon request:

Access through Technology Application:

Please provide Information about the person who will be using the equipment:

Name:

Date of Birth:

Gender:

If recipient is a minor, name of parent/guardian:

Street Address:

City:

State:

Zip:

Primary Phone:

Voice:

TTY:

text message:

video phone:

e-mail:

State in which you are a permanent resident?:

Have you participated in the National Deaf-Blind Equipment Distribution Program before?:

Yes:

No:

If yes, what state/states did you participate in the National Deaf-Blind Equipment Distribution Program?:

List all:

Did you previously receive equipment through National Deaf-Blind Equipment Distribution Program in another State?:

Yes:

No:

If yes, what state/states did you receive equipment through National Deaf-Blind Equipment Distribution Program?:

List all:

Do you have access to the internet, or the ability to get access to the internet, this includes local wifi spots?:

YES:

NO:

Alternate Contact in case of emergency:

Relationship with Applicant:

Street Address:

City:

State:

Zip Code:

Primary Phone:

E-Mail:

Feedback/Suggestions(optional):

END OF SECTION

Financial Eligibility Section. This program is open to individuals based on their financial need:

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 Supplemental Nutrition Assistance Program (SNAP):

Low Income Home Energy Assistance Program:

Medicaid:

National School Lunch Program’s free lunch program:

Supplemental Security Income:

Temporary Assistance for Needy Families:

Income (proof of income required, paystubs, tax returns, SSI or SSDI letter):

What is your gross monthly income?:

What is your family size? If applicant is a minor, include parents in the household and any dependent children, including applicant. If applicant is not a minor, include self, spouse, and any dependent children:

Family size:

END OF SECTION:

Communication Preference:

In this section, put an X after all that apply:

American Sign Language (ASL):

Pidgin Sign Language (PSE):

High Visual Communication Skills:

Tactile Sign Language:

Close-Vision Sign Language:

Other:

END OF SECTION:

Communication Method:

In this section, put an X after all that apply:

Which of these activities do you currently access:

Relay via landline:

Relay via web/computer:

Relay via instant messaging:

TTY via landline :

TTY via web/computer:

TTY via instant messaging:

Videophone:

E-mail:

Text Messaging:

Which equipment do you use to perform the above tasks:

TTY:

Video Equipment:

Deaf Blind Communicator (DBC):

Computer with magnification:

Computer with screen reader:

Computer with Braille display:

iPad or other tablet:

Smart phone:

END OF SECTION:

Reading Method:

In this section, put an X after all that apply:

Print:

Large print:

Braille grade 1 (uncontracted):

Braille grade 2 (contracted):

Computer Braille:

END OF SECTION.

Please read and attest to all previous information is accurate and sign where indicated:

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 representative 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 provided 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 CT Tech Act Project (National Deaf-Blind Equipment Distribution Program):

I authorize Access to Technology (CT Tech Act Project) and BESB (Bureau of Education and Services for the Blind) to discuss my application:

Print Name of applicant or parent/guardian (if applicant is under age 18):

Signature:

Date:

END OF SECTION:

Medical Eligibility:

Disability Verification page must be completed by a doctor, representative of a state agency, or a representative of education:

Disability Verification:

To be completed by a doctor, representative of a state agency, or a representative of education:

Please attach any supplemental documentation you deem necessary:

Name of Applicant:

Qualifying Diagnoses:

1. Does this applicant have a visual acuity of 20/200 or less in the better eye with corrective lenses? YESor NO If “yes”, what is it:

1a. Do you have a reasonable expectation that this applicant will progressively reach a visual acuity loss of 20/200? YES or NO

2. Does this applicant have a chronic hearing impairment, that most speech is not understood with optimum amplification? YES or NO

2a. Do you have a reasonable expectation that this applicants hearing will progress to the point that speech is not understood with optimum amplification? YES or NO

3. Does the combination of conditions listed in 1&2 cause difficulty with independence in daily living, psychosocial adjustment, or obtaining a vocation? YES or NO

Disability Verification provided by:

Name of Attester:

Professional Title:

Agency/Employer:

E-mail:

Phone:

Street Address:

City:

State:

Zip code:

End of section:

Signature and Attestation Statement:

For this program, the term “deaf-blind” has the same meaning given by the Helen Keller National Center Act. In general, the individual must has a certain vision loss and hearing loss that, combined, cause extreme difficulty in attaining independence in daily life activities, achieving psychosocial adjustment, or obtaining a vocation (working):

(1) Any individual:

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:

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:

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 using Telecommunications services, Internet access, and advanced communications 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 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 deaf-blind as defined by the FCC as above:

My Attestation is based on the following:

Attester Signature:

Date:

End of Section:

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):

End Section: