ACCESS TECHNOLOGIES, INC.

iCanConnect – Oregon

Application Section 1 of 6: Instructions and Guidelines

Overview

Access Technologies, Inc. (ATI) has been selected by the Federal Communication Commission (FCC) to administer the National Deaf Blind Equipment Distribution Program (NDBEDP). The NDBEDP distributes 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. The support was mandated by the Twenty-First Century Communications and Video Accessibility Act of 2010 (CVAA). For more information about the NDBEDP, please visit http://accesstechnologiesinc.org/ or http://www.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 family/household income must be below 400% of the Federal Poverty Guidelines, as shown in the table below.

2025 Federal Poverty Guidelines

Number of Persons in Family/Household	400% for everywhere, except Alaska and Hawaii
1	$62,600
2	$84,600
3	$106,600
4	$128,600
5	$150,600
6	$172,600
7	$194,600
8	$216,600

For each additional person add $22,000

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 4 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, and advanced communication 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.

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
- Hearing professional
- Medical/health professional
- School for the deaf and/or blind
- Specialist in Deaf-Blindness
- 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 6 for the disability attestation information that must be provided with this application. If you disagree with the professional's disability decision, please call Access Technologies, Inc. at 503-361-1201 or 1-800-677-7512, or send an email to info@accesstechnologiesinc.org

Access To Telephone Or Internet Services

NDBEDP equipment applicants will need to demonstrate that they have access to the telephone, Internet or wireless services that the equipment is designed to use and make accessible.

Do you need help filling out the application

You may ask another person to fill the application out for you. Note: The individual filling out the application must enter the information of the person who is applying for the equipment.

Application Section 2 of 6: Applicant's Personal Data

Print or type clearly **Please complete all fields**

1. Name of Applicant: _____
2. Date of Birth: _____
3. Gender: _____
4. Community /Facility Name: _____
   (ie nursing home, apartment complex)
5. Home Address:
   _____
6. City/State/Zip Code:
   _____
7. Mailing Address (if different):
   _____
8. City/State/Zip Code:
   _____
9. Home Phone _____ Voice ___ VP __ TTY __
10. Message Phone _____ Voice ___ VP __ TTY __
11. Email: _____
12. Best Time to Contact: _____

13. Preferred Method of Contact:
    Phone _____ Alt Phone ____ Email ____

14. State in which you are a permanent resident: _____

15. Have you participated in iCanConnect before?
    (Check Yes or No) Yes ____ No ___

16. Did you previously receive equipment through iCanConnect in another state? (Check Yes or No) Yes ____ No ___

    If yes, what state/states did you participate in iCanConnect? (*List all*)

    _____

17. Language preference (*Check all that apply)*

ASL ☐	Close Vision ASL/PSE ☐
Tactile ASL/PSE ☐	Pidgin Signed English ☐
Signed English ☐	English Spoken ☐
Spanish Spoken ☐	No Formal Language ☐

    Other. _____

18. Which format do you prefer for written correspondence?

Braille ☐	Email ☐
Large Print ☐	Standard Print ☐

    Other. _____

Alternate Contact (in case of emergency)

1. Alternate contact person: _____
2. City/State/Zip Code: _____
3. Primary Phone: _____
4. Email Address: _____

Application Section 3 of 6: Program Goals

What are your telecommunication goals through participation in the NDBEDP?

_____

_____

_____

_____

_____

Application Section 4 of 6: Income Eligibility

Income eligibility valid for ONE year

To confirm your income eligibility, provide documentation that proves one of the following:

1. 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
    - Veterans and Survivors Pension Benefit, OR

2. Proof of all household income (described in Section 1)

Please 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).

How many people are living in your household? _____

Application Section 5 of 6: Applicant Attestation

1. 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.

2. 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.

3. 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.

4. 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.

5. 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 _____

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

_____

By affixing my name above, I certify that I am signing this application for the applicant and with the applicant's knowledge and consent.

Program Model

iCanConnect-Oregon is a permanent equipment loan program. During this time the title of the equipment remains with Access Technologies, Inc. This allows for flexibility in the sense that as AT changes, or as a client's vision or hearing changes, individuals will be able to upgrade their AT to accommodate these changes as necessary.

Technologies that are traded-in are distributed to another Program consumer or placed in the Device Lending Library; for use during assessments or while a consumer's equipment is being repaired. Additionally, with the onset of the permanent rules, iCanConnect-Oregon has adopted a policy that allows ownership of the AT to transfer to the consumer after five years of using the equipment.

Confidentiality Policy

ATI and iCanConnect are 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. ATI and 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. ATI and iCanConnect are 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 ATI and 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),” 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).

Application Section 6 of 6: Disability 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, then sign and date page 19

1. Name of Applicant: _____
2. Name of Attester: _____
3. Title: _____
4. Agency/Employer: _____
5. City/State/Zip Code: _____
6. E-Mail: _____
7. Primary Phone Number: _____

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(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 applicant’s functional abilities with respect to using Telecommunications service, Internet access

service, and advanced communication 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 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.

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.

1. **Vision Loss:** _____

   _____

   _____

2. **Hearing Loss:** _____

   _____

   _____

3. **Describe how the combination of hearing and vision loss affects this person in daily life.** (See definitions in this section):

_____

_____

_____

_____

_____

_____

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).

Signature _____

Date _____

Send Completed Application
(Sections 2, 3, 4, 5, and 6) to:

By Mail:
Access Technologies, Inc.
2225 Lancaster Drive NE
Salem, OR 97305

By Fax:
Fax: 503-370-4530

By Email:
Email: info@accesstechnologiesinc.org
If submitting scanned documents, please use PDF format.

Questions, please call our office at 503.361.1201

This information is available in alternate format upon request.