iCanConnect Application
(NDBEDP) Missouri Application
The National DeafBlind Equipment Distribution Program

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SECTION 1 – INSTRUCTIONS AND ELIGIBILITY

OVERVIEW

The iCanConnect program (National DeafBlind Equipment Distribution Program) is a direct result of the 21st Century Communications and Video Accessibility Act of 2010. The goal is to ensure that every person who is DeafBlind (with both hearing and vision loss) has access to modern distance communication tools and the training necessary to use them. Missouri Assistive Technology (MoAT) is certified by the FCC to administer the program in the state of Missouri.

WHO IS ELIGIBLE TO RECEIVE EQUIPMENT?

Individuals who have **both** hearing and vision loss and who meet the income eligibility requirements below. 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:

Number of people in family/household	*400%*
1	$63.840
2	$86,560
3	$109,280
4	$132,000
5	$154,720
6	$177,440
7	$200,160
8	$222,880
For each additional person, add	$22,720

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 7 for the family/household income information that must be provided with this application. Income eligibility is valid for one year.

DISABILITY ELIGIBILITY

For this program, iCanConnect 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;

(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
- HKNC representative
- Medical/health professional
- Independent Living Center

- Educator
- School for the deaf and/or blind
- Rehabilitation Services for the Blind
- Vocational Rehabilitation
- Specialist in DeafBlindness
- Speech Pathologist
- Vision professional

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 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.

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),"

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).

Alternative formats of the application available upon request.

Please Complete the Following:

SECTION 2 – APPLICANT INFORMATION

____
Name (Last, First, Middle Initial)

____
Physical Address (Equipment is shipped UPS.)

City	MO State	Zip Code	County

VP or TTY #	Cell Phone	Home or Other Phone

Social Security Number *(Required)*	Date of Birth

☐ YES ☐ NO I am a Missouri resident.

☐ YES ☐ NO I have an e-mail address. E-mail (Print clearly):

☐ YES ☐ NO I have a computer with: (Check the operating system on your computer.)
- ☐ Windows 11 ☐ Windows 10 ☐ iPad or Windows tablet
- ☐ MAC computer ☐ Requesting a Computer

☐ YES ☐ NO I have Internet service. My Internet service provider is: ______________________

☐ YES ☐ NO I have a land-line Telephone. My provider is: ______________________

☐ YES ☐ NO I have a Cell Phone. My provider is: ______________________

SECTION 3 – PROFILE

1. Hearing loss (please check the box that best describes your level of hearing):
   ☐ Deaf ☐ Hard-of-hearing ☐ Late deafened ☐ Can understand speech
   How old were you when this level of hearing loss was noticed? ______________________

2. Vision loss (please check the box that best describes your vision):
   ☐ Blind ☐ Low vision ☐ Close vision ☐ Tunnel vision
   How old were you when you noticed this level of vision? ______________________

3. Do you have any difficulty using your hands for keyboarding, dialing the phone, or holding small objects?
   ☐ Yes ☐ No

4. Communication preference (check all that apply):
   - ☐ Sign Language
   - ☐ Spoken Language, if other than English; (specify): ______________________
   - ☐ International Sign Language (specify): ______________________
   - ☐ Tactile Sign Language
   - ☐ Other (specify): ______________________

5. How do you read? (check all that apply)

- ☐ Regular print
- ☐ Braille
- ☐ Large print
- ☐ Electronic/Screen Reader

SECTION 4 – COMMUNICATION METHODS

1. Which of these activities do you currently perform? Please check all that apply.

- ☐ Amplified telephone calls
- ☐ Relay calls by landline telephone
- ☐ Relay calls with an App
- ☐ Relay calls by web/computer
- ☐ Videophone
- ☐ Email
- ☐ Text messaging
- ☐ Instant messaging
- ☐ Internet surfing / searching
- ☐ Other communication App

2. What equipment do you use to perform the above tasks? Please check all that apply.

- ☐ Landline Phone
- ☐ Video Equipment
- ☐ Computer
- ☐ Computer with screen magnification
- ☐ Computer with speech screen reader
- ☐ Computer with Braille display
- ☐ iPad or other tablet device
- ☐ iPhone or other smart phone

SECTION 5 – PROGRAM GOAL & REQUEST

What is your communication goal through participation in the NDBEDP?

To assist us in helping you to meet your goal and to determine what equipment will support that goal, please check all of the following that apply to you.

1. Equipment for Phone Use:

- ☐ iPhone, with AppleCare warranty
- ☐ Otterbox protective case
- ☐ NeckLoop

2. Equipment for Internet Use:

- ☐ Desktop Computer with large screen
- ☐ Large print keyboard
- ☐ Laptop Computer
- ☐ iPad
- ☐ Bluetooth keyboard with large print for iPad
- ☐ iPad accessories, list: ____________________
- ☐ Braille Display, list if a preference: ____________________
- ☐ Braille Notetaker, list if a preference: ____________________
- ☐ JAWS Screen Reader, or upgrade
- ☐ ZoomText magnification software, or upgrade
- ☐ Fusion software, or upgrade
- ☐ Other, list: ____________________

____

☐ 3. **I DO NOT KNOW what type of equipment I need.**

SECTION 6 – PROFESSIONAL CERTIFICATION OF DISABILITY

Professional must complete and sign this section.

This disability verification section is to be completed by a practicing professional who has direct knowledge of the applicant's **combined** vision and hearing loss. Please complete the following fields, and sign and date at the bottom.

Name and Address of DeafBlind Individual:

Name of Applicant: ____

Street Address: ____________________ **City/State/Zip**: ______________________

Attester Information:

Name of Attester: _________________________ **Title:** ________________________

Agency/Employer: ____

E-mail: _________________________________ **Phone:** ______________________

Street Address: ____________________ **City/State/Zip**: _______________________

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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).

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 that affects functional performance, as defined in the FCC's NDBEDP rules listed directly above):***

Combination of hearing and vision loss: ____

Hearing loss: ____

Vision loss: ____

Attester Signature: _______________________________ Date: _______________

SECTION 7 – APPLICANT SIGNATURE AND PERSONAL RESPONSIBILITY

To confirm your income eligibility, please mail, email 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, email 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). Include a signed statement that attests that what you are submitting represents your total family/household income. Note: income eligibility is valid for one year.

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 authorize Missouri's iCanConnect program to release my name, address, and phone number to a Trainer for purposes of assessment and training.

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. I will care for the equipment and will not hack or physically abuse equipment.

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 (Missouri's DeafBlind Equipment Distribution Program).

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

____

Signature: ___________________________________**Date:** _____________________

Name & relationship of person completing application (if other than applicant), include

Phone & Email: ____

Mail, email, or fax completed application to:

Missouri Assistive Technology (MoAT), iCanConnect Program
1501 NW Jefferson Street
Blue Springs, MO 64015
Ehoutman@mo-at.org
Fax: 816-655-6710
http://at.mo.gov

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