Utah's Equipment Dist. Program
C/O Public Service Commission
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iCanConnect – The National Deaf-Blind Equipment Distribution Program

The National Deaf-Blind Equipment Distribution Program (NDBEDP) ensures that people who have combined hearing and vision loss have access to the telephone, advanced communications and information services. This program was mandated by the 21st Century Communications and Video Accessibility Act of 2010 and established by the Federal Communications Commission. The Utah Public Service Commission has been awarded a grant to provide accessible equipment to people who qualify. The term "Deaf-Blind" is based on criteria established by the Helen Keller National Center Act (see Disability Determination on page 4).

Please fill out pages 1-3 and have page 4 and 5 completed by a medical professional.

APPLICANT'S PERSONAL INFORMATION (PRINT LEGIBLY)

Full Name (Mr., Mrs., Ms.) (Please Print)	Area Code & Phone Number
Alternative Phone Number with Area Code	Date of Birth (Month/Day/Year)
Street Address (apartment number if applicable)	City, State, Zip Code
Post Office Box (if necessary)	E-mail Address (optional)

AN ALTERNATE CONTACT PERSON OR GUARDIAN WHO MAY BE PRESENT DURING MY APPOINTMENT AND/OR WHO CAN BE CONTACTED TO SET UP AN APPOINTMENT:

Full Name	Relationship	Area Code & Phone Number

If my monthly income increases, and/or I no longer receive state or federal assistance, I will IMMEDIATELY notify the Public Service Commission.

I will notify the Public Service Commission if and when I no longer reside in the State of Utah as well as provide a forwarding address. My family will return the device upon my death. I understand if I give false information, I must IMMEDIATELY return the equipment to the PSC.
I understand it is my responsibility to obtain telephone or internet service, and I assume the responsibility for payment of all associated fees and charges of that service. I agree to use the equipment solely for the purposes intended, and I may not sell, lend or transfer the equipment or services provided to me.

Signature of Applicant	Printed Name	Date
Signature of Parent or Legal Guardian (if under 18)	Printed Name	Date

Are you currently receiving services or comparable benefits through the following agencies or service providers?

☐ YES ☐ NO Vocational Rehabilitation
☐ YES ☐ NO Independent Living Services
☐ YES ☐ NO Public School System
☐ YES ☐ NO Veteran's Administration
☐ YES ☐ NO Currently employed?

FINANCIAL ELIGIBILITY

To confirm eligibility, please provide a copy of last year's Federal 1040 IRS tax form or documentation that proves your eligibility for one of the following federal low-income programs. Please select YES or NO for the following: (see income requirements below)

☐ YES ☐ NO Supplemental Security Income (SSI) or Social Security Disability Income (SSDI)
☐ YES ☐ NO Medicaid
☐ YES ☐ NO HEAT (Home Energy Assistance Target Program)
☐ YES ☐ NO Food Stamps or SNAP (Supplement Nutrition Assistance Program)
☐ YES ☐ NO Temporary Assistance to Needy Families (TANF)
☐ YES ☐ NO Federal Public Housing assistance, including Section 8 Housing

Telephone/Internet Equipment and Services

YES NO Do you presently have landline and/or Internet phone service in your home?

Income

Total Household Income: $_____/**per year** Total Number of Persons in Household:_____

Maximum Household Income Allowed to Qualify

Household Size	Gross Annual Income	Gross Monthly Income
1	$45,960	$3,830
2	$62,040	$5,170
3	$78,120	$6,510
4	$94,200	$7,850
5*	$110,280	$9,190

**For each additional household member, please add $16,080 per year.*
Source: US Department of Health and Human Services.

Disability Verification

DISABILITY ELIGIBILITY
The following two sections below are to be completed by a practicing professional (see page 5) who have direct knowledge of your vision and hearing loss.

The term "blind" is defined through the Helen Keller National Center Act as:
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 of 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 cause extreme difficulty in attaining independence in daily life activities, achieving psychosocial adjustment, or obtaining a vocation; 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.

VISION CERTIFICATION
Please Mark:
Legally Blind _____
Field Restriction greater than 20 degrees _____
Or a
Progressive Condition Leading to Blindness_____ (Macular Degenaration, RP, etc.)

Name of Certifier (Please Print)			
Title and Agency/Business Name			
Office Address	City	Zip Code	Phone Number

I certify under penalty of law that this individual is blind as defined above by the Helen Keller National Center Act.

*SIGNATURE:*_____*DATE:*_____

The term "deaf" is defined as 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. (moderate-severe to profound loss, or poor discrimination.)

HEARING CERTIFICATION

Name of Certifier (Please Print)			
Title and Agency/Business Name			
Office Address	City	Zip Code	Phone Number

I certify under penalty of law that this individual is deaf as defined above by the Helen Keller National Center Act.

*SIGNATURE:*_____*DATE:*_____

I understand that equipment purchases are based on my ability to demonstrate benefit in overcoming my barriers to deaf-blindness as defined by the NDBEDP grant.

WHO CAN CERTIFY THIS APPLICATION, VERIFYING DISABILITY?

Audiologist
Community-based service provider
Educator
Hearing Professional
HKNC National Deaf-Blind Registry
Medical/health professional
School for the Deaf or Blind
Speech Pathologist
Vision Professional
Vocational Rehabilitation Counselor

This document is available in other formats upon request.

Updated 2/26/2013