iCanConnect Delaware UD CDS logos
This program is administered by the University of Delaware's Center for Disabilities Studies.

# The National Deaf-Blind Equipment Distribution Program Eligibility Guidelines

The National Deaf-Blind Equipment Distribution Program (NDBEDP) supports local programs that distribute 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. 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). The Center for Disabilities Studies (CDS) was selected by the FCC to administer the NDBEDP in Delaware. CDS has partnered with Delaware’s Division for the Visually Impaired (DVI) and Delaware Program for Children with Deaf-Blindness in order to administer the program. For more information about the NDBEDP program go to https://www.fcc.gov/general/national-deaf-blind-equipment-distribution-program or http://icanconnect.org/.

# Income Eligibility

To be eligible, you must **EITHER** have a total family/household income below 400% of the Federal Poverty Guidelines (FPG) **OR** currently be enrolled in a federal program with an income eligibility requirement that does not exceed 400% of the FPG. In other words, if you qualify for Medicaid, Supplemental Security Income (SSI), Federal public housing assistance of Section 8, Food Stamps or the Supplemental Nutrition Assistance Program (SNAP), you meet the income eligibility requirement for the iCanConnect program. You also meet income eligibility requirements if your family/household income is below the thresholds noted below. For example, a family of four can have an income up to $128,600 and meet the income eligibility requirements for the iCanConnect program.

**2025 Federal Poverty Guidelines for Delaware residents**

# of persons in family or household and maximum income permitted.

|  |  |
| --- | --- |
| 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 to the maximum income permitted

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 “Income Eligibility” (page 12) in the application for the family/household income information that must be provided when applying.

# 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 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
* Community-based Service Provider
* Educator
* Hearing Professional
* HKNC Representative
* Medical/Health Professional
* School for the deaf or deaf-blind
* Specialist in Deaf-Blindness
* Speech Language 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 deaf-blind, such as an individualized education program (IEP) or a Social Security determination letter, may serve as verification of disability.

See the application (pages 14-16) for the disability attestation information that must be provided with the application.

# Confidentiality Policy

iCanConnect Delaware is committed to ensuring that your privacy is protected. Information provided on your 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.

# Applying for Services

If you think you or someone that you know is eligible contact Allison Berdoulay at 302-831-3632; or email aberd@udel.edu for an application.

# Do you need help?

If you are unable to fill out the application yourself, you may ask another person to fill it out for you. Some people to ask for help might be (but are not limited to) a family member, friend, caregiver, guardian, case manager, doctor, audiologist, or another professional. The person who is filling out the application must enter the information of the person who is applying for the equipment.

# Do You Need Help in Finding Equipment to Meet Your Needs?

Several organizations are working together to help you figure out the best equipment for your needs. These include the Delaware Division for the Visually Impaired, the Delaware Program for Children with Deaf-Blindness, and the Delaware Assistive Technology Initiative at the University of Delaware’s Center for Disabilities Studies. If you already have a relationship with one of these organizations, contact them for an application. They will work with the other partners to help you make good equipment decisions. See contact information for these organizations below.

**Allison Berdoulay**

DATI/University of Delaware

Center for Disabilities Studies

461 Wyoming RD

Newark, DE 19716

aberd@udel.edu

302-831-3632 Voice; 302-831-4689 TDD or dial 711 for Relay

302-831-4690 Fax

**Sandra Miller**

DHSS/Division for the Visually Impaired

1901 N DuPont Hwy

Biggs Building

New Castle, DE 19720

Sandra.miller@delaware.gov

302-255-9811 Voice; 302-255-9854 TDD (dial 711 for Relay)

302-255-9388 Fax

**(Contact TBD)**

Delaware Program for Children with Deaf-Blindness

630 E Chestnut Hill RD

Newark, DE 19713

302-454-2305 Voice; 302-722-4317 VP (dial 711 for Relay)

302-454-2497 Fax

iCanConnect Delaware

National Deaf-Blind Equipment Distribution Program

iCanConnect Delaware

# National Deaf-Blind Equipment Distribution Program Application

Review the National Deaf-Blind Equipment Distribution Program Eligibility Guidelines for more detail before beginning this application process.

# Applicant’s Personal Information

1. Last name, first name, middle initial:

2. Date of Birth:

3. Gender:

4. Home address City, State, and Zip:

5. Mailing address (if different) City, State and Zip:

6. Community or Facility name (i.e., nursing home, apartment complex)

7. County:

8. Primary phone number, (include area code):

9. Alternate phone number (include area code):

10. E-mail address:

11. State in which you are a permanent resident:

12. Have you participated in iCanConnect (the National Deaf-Blind Equipment Distribution Program) before? (\_\_Yes \_\_No)

If yes, in which state(s) did you participate in iCanConnect? (list all)

13. Did you previously receive equipment through iCanConnect in another state? \_\_Yes \_\_No

If yes, what state/states did you receive equipment through iCanConnect? (list all):

14. Applicant’s Language Preference: (select one)

\_\_ English – Spoken

\_\_ American Sign Language (ASL)

\_\_ Signed English

\_\_ Spanish – Spoken10

\_\_ No Formal Language

\_\_ Tactile ASL/PSE

\_\_ Close Vision ASLP/PSE

\_\_ Pidgin Signed English

\_\_ Other (describe)

15. Which format do you prefer for written correspondence? (select one)

\_\_ Braille

\_\_ Email

\_\_ Large Print

\_\_ Standard Print

\_\_ Other (describe)

16. Contact By: (select and describe):

\_\_ E-mail

\_\_ Fax

\_\_ Text Messaging

\_\_ TTY Phone (dial 711 for Relay)

\_\_ Phone – Voice

\_\_ Video Phone

17. Alternate Contact (in case of an emergency):

18. Relationship with Applicant:

19. Street Address:

20. City, State, and Zip:

21. Primary Phone:

22. Email:

23. How many people are in your household:

24. Are you currently being served by another service system?

If yes, does your current equipment choice used in another setting continue to meet your telecommunications needs? \_\_Yes \_\_No

25. Will you give us permission to contact others who may have information relative to your application? \_\_Yes \_\_No

# Feedback/Suggestions (optional)

26. How did you hear about this program? (select all that apply)

\_\_ iCanConnect.org website

\_\_ Conference or seminar

\_\_ Disability Advocacy Group

\_\_ Education Provider/School

\_\_ Family Member

\_\_ Friend

\_\_ Healthcare Provider

\_\_ Helen Keller National Center (HKNC) Representative

\_\_ Independent Living Center

\_\_ Interpreter

\_\_ Media/News (television, magazine, radio)

\_\_ Medical Provider

\_\_ Senior Center

\_\_ Social Media (Facebook, Twitter)

\_\_ Specialist in Deaf-Blind Services

\_\_ State Deaf/Blind Project

\_\_ Technology Vendor

\_\_ VR Counselor

\_\_ Other Professional

\_\_ Other – general

27. Race/Ethnicity (optional, not required):

Are you of Hispanic origin? \_\_Yes \_\_No

The Spanish/Hispanic/Latino question is about ethnicity, not race. Please continue to answer the following question by marking one or more boxes to indicate what you consider your race to be (select one):

\_\_ White

\_\_ Black or African American

\_\_ American Indian or Alaskan Native

\_\_ Native Hawaiian or Pacific Islander

\_\_ Asian

\_\_ Other race

28. Are you a veteran? \_\_Yes \_\_No

# Income Eligibility

To confirm your income eligibility, please mail or fax documentation that confirms your enrollment 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). 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.

# Applicant Attestation (signature required)

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. 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 iCanConnect (the National Deaf-Blind Equipment Distribution Program).

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

**Signature**: **Date**:\_\_\_\_\_\_\_\_\_

Relationship to Applicant:

Telephone number (include area code):

# Verification of Disability (to be completed by a professional)

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 or deaf-blind
* Specialist in Deaf-Blindness
* Speech Language Pathologist
* State equipment/assistive technology program
* Vision Professional
* Vocational Rehabilitation Counselor

Please complete the following fields, and sign and date at the bottom.

# Name and Address of Deaf-Blind Individual:

Name of Applicant:

Street Address:

City, State, and Zip:

# Attester Information:

Name of Attester:

Title:

Agency/Employer:

E-mail:

Phone:

Street Address:

City, State, and Zip:

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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.

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(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.

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).

# To be completed by the attester:

My attestation is based on the following: (explain)

Attester signature:

Date:

Printed Name:

Professional title:

License/certificate number:

Agency Name:

Email:

Phone:

Street Address:

City, State, and Zip:

iCanConnect logo:

iCanConnect (in blue and green letters against white background)
The National Deaf-Blind Equipment Distribution Program (in white letters against a black background)

**Applicant attestation** (signature required)

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. 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 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.

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 iCanConnect (the National Deaf-Blind Equipment Distribution Program).

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

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Signature:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Date:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

If this 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.

# Submit the completed application and supporting documents to:

Allison Berdoulay

DATI/University of Delaware

Center for Disabilities Studies

461 Wyoming RD

Newark, DE 19716

aberd@udel.edu

302-831-3632 Voice; 302-831-4689 TDD or dial 711 for Relay

302-831-4690 Fax (This document is available upon request in alternate formats.)

# 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).