iCanConnect

The National Deaf-Blind Equipment Distribution Program

APPLICATION

iCanConnect/GA www.GCDHH.org/icc

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The National Deaf-Blind Equipment Distribution Program

Program Information

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The National Deaf-Blind Equipment Distribution Program

The National DeafBlind Equipment Distribution Program (NDBEDP) supports local programs that distribute equipment to low-income individuals who are DeafBlind (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). For more information about the NDBEDP, please visit http://icanconnect.org or http://www.fcc.gov/ndbedp.

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Who is eligible to receive equipment?

Under the CVAA, only low-income individuals who are DeafBlind are eligible to receive equipment provided through the NDBEDP.

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:

2025 Federal Poverty Guidelines			
Number of persons in family/household	400% for everywhere, except Alaska and Hawaii	400% for Alaska	400% for Hawaii
1	$62,600	$78,200	$71,960
2	$84,600	$105,720	$97,280
3	$106,600	$133,240	$122,600
4	$128,600	$160,760	$147,920
5	$150,600	$188,280	$173,240
6	$172,600	$215,800	$198,560
7	$194,600	$243,320	$223,880
8	$216,600	$270,840	$249,200
For each additional person, add	$22,000	$27,520	$25,320
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 "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; and
- (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 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 DeafBlind 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 and/or Blind
- Specialist in DeafBlindness
- Speech 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 DeafBlind, such as an individualized education program (IEP) or a Social Security determination letter, may serve as verification of disability. See Section 5 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.

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The National Deaf-Blind Equipment Distribution Program

Application

Applicant Information

Name:_____

Date of Birth: ___/___/___

Address: _____

_____

Primary Phone: _____

Secondary:_____

Voice: ☐ TTY: ☐ VP: ☐

Email:_____

Permanent State of Residence: _____

County: _____

Number of Household Residents: _____

Having application trouble?
Contact US
info@gcdhh.org

Section 1

Applicant Questionnaire

Have you participated in iCanConnect (the National DeafBlind Equipment Distribution Program) before? ◯ Yes ◯ No

If yes, what state/states did you participate in iCanConnect? (list all): _____

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):

_____

Language preference (check all that apply):
☐ ASL ☐ Close Vision ☐ ASL/PSE ☐ Tactile
☐ ASL/PSE ☐ English (spoken)
☐ No Formal Language ☐ Pidgin Signed English
☐ Signed English ☐ Spanish (spoken)
☐ Other: _____

Which format do you prefer for written correspondence? ☐ Braille ☐ E-mail
☐ Large Print ☐ Standard Print
☐ Other: _____

Contact By: ☐ E-mail ☐ Fax ☐ Text Message
☐ Phone (voice) ☐ TTY (dial 711 for Relay)
☐ Video Phone

How did you learn about the program? _____

Alternate Contact Info

Emergency Contact Name: _____

Relationship to Applicant: _____

Street Address: _____

_____

Primary Phone: _____

Secondary: _____

Email: _____

Emergency Contact Preferred Method of Communication:

Phone (Voice): ☐ Email: ☐

Text Message: ☐ Fax: ☐

Having application trouble?
Contact Us
info@gcdhh.org

Income Eligibility

To confirm your income eligibility, please mail or fax 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:
   a. Medicaid
   b. Supplemental Security Income (SSI)
   c. Federal public housing assistance or Section 8
   d. Food Stamps or Supplemental Nutrition Assistance Program (SNAP)
   e. Veterans and Survivors Pension Benefit; OR
2. Proof of all household income

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).

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 DeafBlind Equipment Distribution Program).

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

Signature:_____Date: _____

Disability Verification

Easy as 1 2 3

1. Obtain a copy of your most recent visual acuity report and a statement from a vision professional that proves *progressive vision loss* or 20/200 vision in the better eye.

2. Obtain a copy of audiograms and a statement from a hearing professional that proves *progressive hearing loss* or hearing loss that impedes an individual's ability to understand speech with optimum amplification.

3. Mail, email, or fax proof of both disabilities to our office to be verified by an ICC team member.

GCDHH follows the definition of "DeafBlind" as is written in The Helen Keller Act – U.S. Code, Title 29-Labor, Chapter 21 Section 1905.

This disability verification section is to be completed by a practicing professional who has direct knowledge of the applicant's vision loss.

1

NAME AND ADDRESS OF DEAFBLIND INDIVIDUAL:

Name of Applicant: _____

Street Address: _____

City/State/Zip:_____

ATTESTER INFORMATION: (Statement from Vision Professional Required)

Name of Attester:_____Title:_____Agency/Employer:_____

E-mail:_____Phone:_____

Office Street Address: _____

City/State/Zip: _____

For this program, the CVAA 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; **and**

(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 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 DeafBlind 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.

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: _____

_____

_____

Attester Signature:_____Date:_____

Please attach a copy of the individual's visual acuity report.

This disability verification section is to be completed by a practicing professional who has direct knowledge of the applicant's hearing loss.

2

NAME AND ADDRESS OF DEAFBLIND INDIVIDUAL:

Name of Applicant: _____

Street Address: _____

City/State/Zip:_____

ATTESTER INFORMATION: (Statement from Hearing Professional Required)

Name of Attester:_____Title:_____Agency/Employer:_____

E-mail:_____Phone:_____

Office Street Address: _____

City/State/Zip: _____

For this program, the CVAA 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).**

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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: _____

_____

_____

Attester Signature:_____Date:_____

Please attach a copy of the individual's audiograms.

Disability Verification

Mail, email, or fax proof of both disabilities (statements and copies of the visual acuity report and audiograms) along with a completed application to our office to be verified by an ICC team member.

Georgia Center of the Deaf and Hard of Hearing

2296 Henderson Mill Rd #115
Tucker, GA 30345
1-888-297-9461
VP: 404-381-8448
Fax: 404-297-9465
info@gcdhh.org

Mail, email, or fax your completed application and all seven sections to:

Georgia Center of the Deaf and Hard of Hearing
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Fax: 404-297-9465
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iCanConnect Checklist

- [ ] 1. Applicant Information
- [ ] 2. Applicant Questionnaire
- [ ] 3. Alternate Contact Info
- [ ] 4. Income Eligibility
- [ ] 5. Applicant Attestation
- [ ] 6. Disability Verification

Mail, email, or fax completed application and all six parts to:

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GEORGIA CENTER OF THE DEAF AND HARD OF HEARING

iCanConnect/GA

Accessibility, Connection, and Equality

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