

# iCanConnect

## The National Deaf-Blind Equipment Distribution Program

### Application Section 1 of 3: Instructions and Guidelines

#### Overview

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). For more information about the NDBEDP, please visit <http://icanconnect.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 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 2 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 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 and/or blind
- Specialist in Deaf-Blindness
- Speech pathologist
- State equipment/assistive technology program
- Vision professional
- Vocational rehabilitation counsellor

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.

See Section 3 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.



**The National Deaf-Blind Equipment Distribution Program**

**Application Section 2 of 3: Applicant's Personal Data**

(Please fill in all fields)

**Name of Applicant:** \_\_\_\_\_

**Date of birth:** \_\_\_\_\_ **Gender:** \_\_\_\_\_

*(If you are under age 18, your parent or legal guardian must sign the application.)*

**Street Address:** \_\_\_\_\_

**City/State/Zip Code:** \_\_\_\_\_

**Primary Phone:** \_\_\_\_\_ **Voice** \_\_\_ **TTY** \_\_\_ **VP** \_\_\_

**Alternate Phone:** \_\_\_\_\_ **E-mail:** \_\_\_\_\_

**State in which you are a permanent resident** \_\_\_\_\_

**Have you participated in iCanConnect (the National Deaf-Blind Equipment Distribution Program) before?** *(check Yes or No)* Yes \_\_\_ No \_\_\_

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

**Did you previously receive equipment through iCanConnect in another state?**  
*(check Yes or No)* Yes \_\_\_ No \_\_\_

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

**How many people are living in your household?** \_\_\_\_\_

**Language preference (check all that apply):**

- |   |  |
|---|--|
| <input type="checkbox"/> ASL                | <input type="checkbox"/> Close Vision ASL/PSE  |
| <input type="checkbox"/> Tactile ASL/PSE    | <input type="checkbox"/> English (spoken)      |
| <input type="checkbox"/> No Formal Language | <input type="checkbox"/> Pidgin Signed English |
| <input type="checkbox"/> Signed English     | <input type="checkbox"/> Spanish (spoken)      |
| <input type="checkbox"/> Other _____        |  |

**Which format do you prefer for written correspondence?**

- |                                      |   |
|--------------------------------------|---|
| <input type="checkbox"/> Braille     | <input type="checkbox"/> E-mail         |
| <input type="checkbox"/> Large Print | <input type="checkbox"/> Standard Print |
| <input type="checkbox"/> Other _____ |   |

**Prefer to be contacted by:**

- |                                       |   |
|---------------------------------------|---|
| <input type="checkbox"/> E-mail       | <input type="checkbox"/> Fax                      |
| <input type="checkbox"/> Text Message | <input type="checkbox"/> TTY (dial 711 for Relay) |
| <input type="checkbox"/> Video Phone  | <input type="checkbox"/> Phone (voice)            |

**Alternate Contact (in case of emergency):** \_\_\_\_\_

**Relationship with Applicant:** \_\_\_\_\_

**Street Address:** \_\_\_\_\_

**City/State/Zip Code:** \_\_\_\_\_

**Primary Phone:** \_\_\_\_\_

**E-mail:** \_\_\_\_\_

**Feedback/Suggestions (optional):** \_\_\_\_\_

**How did you hear about this program?**

- |   |  |
|---|--|
| <input type="checkbox"/> iCanConnect.org website                    | <input type="checkbox"/> Conference or Seminar             |
| <input type="checkbox"/> Disability advocacy group                  | <input type="checkbox"/> Specialist in Deaf-Blind Services |
| <input type="checkbox"/> Education provider /School                 | <input type="checkbox"/> Family Members                    |
| <input type="checkbox"/> Friends                                    | <input type="checkbox"/> Healthcare provider               |
| <input type="checkbox"/> Interpreter                                | <input type="checkbox"/> Senior Center                     |
| <input type="checkbox"/> Helen Keller National Center               | <input type="checkbox"/> Technology vendor                 |
| <input type="checkbox"/> (HKNC) representative                      |  |
| <input type="checkbox"/> Independent Living Center                  |  |
| <input type="checkbox"/> News / Media (television, magazine, radio) |  |
| <input type="checkbox"/> Social Media (Facebook, Twitter)           |  |
| <input type="checkbox"/> State Deaf-Blind Project                   |  |
| <input type="checkbox"/> Vocational Rehabilitation Counselor        |  |
| <input type="checkbox"/> Other _____                                |  |

## **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 (as 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).

**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):**

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

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

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

# iCanConnect

The National Deaf-Blind Equipment Distribution Program

## Application Section 3 of 3: 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, and sign and date at the bottom.

### ***Name and Address of Deaf-Blind 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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(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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**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).

**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):***

**Vision loss:** \_\_\_\_\_

\_\_\_\_\_

**Hearing loss:** \_\_\_\_\_

\_\_\_\_\_

**Describe how the combination of hearing and vision loss affects this person in daily life** (Please refer to the definition of deaf-blind in this section of the application):

\_\_\_\_\_

\_\_\_\_\_

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

**Mail, e-mail, or fax completed application (Sections 2 and 3) to:**

Hailey King  
Deaf Service Program Specialist

Department of Human Services – Division of Rehabilitation Services  
1501 S Highline Avenue  
Suite 1C  
Sioux Falls, South Dakota 57110

E-mail: Hailey.King@state.sd.us  
• Telephone: 605-362-3630 • Fax: 605-367-5327

If scanned documents are submitted, please use PDF format.  
(This document is available upon request in hard copy print, braille, and electronic text.)

**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).