iCanConnect - Oregon

Application

OVERVIEW

Access Technologies, Inc. (ATI) has been selected by the Federal Communication Commission (FCC) to administer the National Deaf Blind Equipment Distribution Program (NDBEDP). The NDBEDP distributes 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. The support was mandated by the Twenty-First Century Communications and Video Accessibility Act of 2010 (CVAA). For more information about the NDBEDP, please visit http://accesstechnologiesinc.org/ or http://www.fcc.gov/ndbedp .

WHO IS ELIGIBLE TO RECEIVE EQUIPMENT?

Applicant must meet the following criteria to be eligible to participate in the NDBEDP:

Financial Eligibility: To be eligible, your family/household income must be below 400% of the Federal Poverty Guidelines, as shown in the following table:

2017 Federal Poverty Guidelines

Persons in Family/Household	400% for the 48 contiguous states and the District of Columbia
1	$48,240
2	$64,960
3	$81,680
4	$98,400
5	$115,120
6	$131,840
7	$148,560
8	$165,280
For each additional person, add	$16,720
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 2 for the family/household income information that must be provided with this application.

Medical Eligibility: Applicants must meet the Helen Keller National Center (HKNC) definition of Deaf-Blind which states an individual is deaf-blind when they have

1. 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**

2. 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**

3. for whom the combination of impairments described in clauses (1) and (2) cause extreme difficulty in attaining independence in daily life activities, achieving psychosocial adjustment, or obtaining a vocation.

Program Model

For the purpose of the Pilot Program, Oregon has established a permanent equipment loan program. During this time the title of the equipment remains with Access Technologies, Inc. This allows for flexibility in the sense that as AT changes, or as a client's vision or hearing changes, individuals will be able to upgrade their AT to accommodate these changes as necessary. The technologies which are traded-in will be placed in a Device Lending Library. At the conclusion of the pilot program, Oregon will adopt a policy that allows ownership of the AT to transfer to the consumer after five years of using the equipment.

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
Educator
Medical/health professional
Specialist in Deaf-Blindness
Vocational rehabilitation counselor
Community-based service provider
Hearing professional
School for the deaf and/or blind
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 deaf-blind, such as an individualized education program (IEP), or a statement from a public or private agency, such as a Social Security determination letter, may serve as verification of disability.

If you disagree with the professional's disability decision, please contact Access Technologies, Inc. 503-361-1201, or 1-800-677-7512 info@accesstechnologiesinc.org

See Section 5 for the disability attestation information that must be provided with this application.

Confidentiality policy
ATI and iCanConnect are 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. ATI and 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. ATI and iCanConnect are 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.

Access to Telephone or Internet Services: NDBEDP equipment applicants will need to demonstrate that they have access to the telephone, Internet or wireless services that the equipment is designed to use and make accessible.

Do you need help filling out the application?
If you are unable to fill out the application yourself, you may ask another person to fill it out for you. The person who is filling out the application must enter the information of the person who is applying for the equipment.

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*)
_____

Print or type clearly

Please fill in all fields

Application Section 1of 5: Applicant's Personal Data

1. Last name, First name, Middle initial	2. Gender ☐ Male ☐ Female
3. Home address City State Zip Code	
4. Mailing address (if different) City State Zip Code	
5. Community/Facility name (i.e., nursing home, apartment complex)	6. County
7. Home telephone number (include area code) ( ) ☐Voice ☐VP ☐TTY ☐Fax	8. Message telephone number (include area code) ( ) ☐Voice ☐VP ☐TTY ☐Fax
9. E-mail address	10. Best times to contact
11. Preferred method of contact ☐ phone ☐ alt phone ☐ email	
12. Social Security Number (optional)	13. Date of Birth (MM/DD/YYYY)

Application Section 2 of 5: Financial Income

14. Financial information:

If you are enrolled in a federal subsidy program with an income threshold that does not exceed 400% of the Federal Poverty Guideline, you meet the income eligibility for the NDBED Program. Please attach a proof of enrollment.

If you are not enrolled in a federal subsidy program please provide the following:

Family size: _____ (parents in the household and any dependent children, including the applicant)

Monthly Gross Income: $ _____

Estimated Annual Gross Income: $ _____

To confirm your income eligibility, please mail or fax documentation that proves your eligibility from one of the following federal programs: SSI, SSDI, Medicaid, Low income home energy assistance, Federal public housing assistance or Section 8, Food Stamps or Supplement Nutrition Assistance Program, Temporary Assistance for Needy Families, Welfare to Work, or National School Lunch Program's free lunch program.

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 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 is your only source of income.

Application Section 3 of 5: Program Goals

What are your telecommunication goals through participation in the NDBEDP?

Application Section 4 of 5: Client Signature

1. 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.

2. 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.

3. 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.

4. 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.

5. I certify that I have read, understand, and accept these conditions to participate in iCanConnect (the National Deaf-Blind Equipment Distribution Program).

Signature _____ Date _____

Person completing application (if other than applicant) Name Relationship	Alternate contact person (for applicant) Name Relationship
2a.Telephone number (include area code) ( ) ☐ Voice ☐ VP ☐ TTY ☐ Fax	3a.Telephone number (include area code) ( ) ☐Voice ☐ VP ☐ TTY ☐ Fax
2b. Email address	3b. Email address

Application Section 5 of 5: Disability Verification

To be completed by a **medical** or **health professional**; hearing, speech or vision specialist; representative of a state agency, or a representative of education.

Vision Status:

Does the applicant have a visual acuity of 20/200 or less? ☐ Yes ☐ No

Does the applicant have a field defect of 20 degrees or less? ☐ Yes ☐ No

Do you have a reasonable expectation that this applicant will progressively reach a visual acuity of 20/200 or a field defect of 20 degrees or less? ☐ Yes ☐ No

Hearing Status:

Does this applicant have a chronic hearing impairment so severe that most speech is not understood with optimum amplification? ☐ Yes ☐ No

Do you have a reasonable expectation that this applicant's hearing will progress to the point that most speech is not understood with optimum amplification? ☐ Yes ☐ No

Independence Status:

Does the combination of the vision and hearing loss cause the applicant difficulty in attaining independence in daily living activities, achieving psychosocial adjustment, or obtaining a vocation? ☐ Yes ☐ No

Disability Verification provided by:

Professional Signature _____ Date _____

Printed Name and Title _____

Mailing address	E-mail address

Telephone number (include area code)

( ) ☐ Voice ☐ VP ☐ TTY

Mail completed application to:

Access Technologies, Inc.
ATTN: NDBEDP
2225 Lancaster Drive NE
Salem, OR 97305

This information is available in alternate format upon request.