University of Idaho

Idaho Assistive Technology Project

1187 Alturas Drive
Moscow, Idaho 83843-8331

Phone: 1-800-208-432-8324
Fax: 208-885-6102
www.idahoat.org
www.idahoat4all.com

Idaho-National Deaf/Blind Equipment Distribution Project
Application

This application is for specialized equipment for individuals who are deaf-blind as defined by the Helen Keller Act. The term ‘deaf/blind’ refers to individuals with a combined hearing and vision loss. Some individuals are profoundly deaf and totally blind. Other individuals have varying hearing and vision loss. This application is to request assistive technology devices and services to effectively access distance communication such as: telecommunication services, Internet access services, and advanced communications, including interexchange services and advanced telecommunications and information services.

To be eligible for equipment in Idaho, you must be an Idaho resident.

SECTION 1. Information about the person who will be using the equipment:

1. Last name, first name, middle initial

2. Gender
❒Male ❒Female

3. If recipient is a minor, name of parent/guardian

4. Date of Birth (MM/DD/YYYY)

5. Home Address City State Zip Code

6. Mailing Address (if different) City State Zip Code

7. Daytime phone number
Voice VP
TTY FAX

8. Alternate phone number
❒Voice VP
TTY FAX

9. E-mail address

10. Preferred Method of Contact ☐phone ☐alt phone ☐e-mail

11. Best time to contact

12. Do you have access to the internet, or the ability to get access to the internet?
(Includes local WI-FI spots) YES NO

SECTION 2. Person requesting the equipment, if other than recipient:

1. Name
2. Title

3. Daytime phone number
( )

4. Alternate phone number
( )

5. Name of agency

6. Address City State Zip Code

7. E-mail address

8. Relationship to recipient

SECTION 3. Financial Eligibility

This program is open to individuals based on their financial need. Individuals or families must have income less that 400% of the 2016 Federal Poverty Guidelines (48 contiguous states & DC).

Household size	**400%**
1	$47,520
2	64,080
3	80,640
4	97,200
5	113,760
6	130,320
7	146 920
8	163,560
For each additional person, add	$16,640

Income (Please check)

- ❒ Paystub
- ❒ Income Tax Returns
- ❒ SSDI letter
- ❒ SSI

Gross monthly income ________________
(all income from earned and unearned sources)

Family size ____
(parents in the household and any dependent children, including applicant)
Please check if you receive government assistance under any of the programs below:

- ❒ Federal Public Housing Assistance or Section 8
- ❒ Supplemental Nutrition Assistance Program
- ❒ Low Income Home Energy Assistance Program
- ❒ Medicaid
- ❒ National School Lunch Program's free lunch program
- ❒ Supplemental Security Income
- ❒ Temporary Assistance for Needy Families

SECTION 4. **Medical Eligibility**
Page 4 of this application must be completed by a doctor, representative of a state agency, or a representative of education.

Please be aware that there is a limited amount of funds available.

Where to Send Your Application

Please return this application via one of the following methods:

Mail: Idaho Assistive Technology Project (IATP)
1187 Alturas Drive
Moscow, ID 83843
ATTN: Idaho-NDBEDP

Fax: 208-885-6145

For more information contact the Idaho Assistive Technology Project at 1-800-432-8324.

In compliance with the Americans with Disabilities Act, this information is available in alternate formats upon request.

Disability Information

Name of Applicant: ____

Qualifying Diagnoses: ____

Vision:

1. Does this applicant have:
   a) a visual acuity of 20/200 or less in the better eye with corrective lenses; **or,**
   b) a field defect such that the peripheral diameter of visual field subtends an angular distance no greater than 20 degrees; **or**,
   c) a progressive visual loss having a prognosis leading to one or both of these conditions?

   ❒YES If "yes", is it a, b or c?
   ❒______________________ NO

Hearing:

2. Does this applicant have:
   a) a chronic hearing impairment so severe that most personal or distance conversations cannot be understood with optimum amplification; **or**,
   b) a progressive hearing loss having a prognosis leading to this condition?

   ❒YES If "yes", is it a or b?
   ❒______________________ NO

AND…….

Vision and Hearing:

3. Does the combination of vision and hearing loss cause difficulty with functional independence with regard to daily living activities including communication with someone who is not in the same room, psychosocial adjustment, or obtaining a vocation (working)?

   ❒YES
   ❒NO
   If Yes, please explain:____ Please attach any additional documentation as needed.

Disability Verification is provided by:

Name _____________________________ **Professional Title** ________________

E-mail _________________________ **Phone** ____________________________

Address ____

Verification can be a doctor, representative of a state agency, or a representative of education. Verifying individual does so under threat of perjury.