

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 than 400% of the 2017 Federal Poverty Guidelines (48 contiguous states & DC).

Household size	400%
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

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.