2020 CONSUMER APPLICATION

iCanConnect/NJ
The National Deaf-Blind Equipment Distribution Program

❑ First Time Applying
❑ Returning Consumer

Applicant Name:_____
DOB:_____
Address:_____
City:_____
Zip Code:_____
Primary Contact Number:_____ ☐ Home ☐ Cell
This is a: ☐ Voice ☐ VP ☐ Text ☐ TTY
Secondary Contact Number: _____ ☐ Home ☐ Cell
This is a: ☐ Voice ☐ VP ☐ Text ☐ TTY
E-mail:
_____
Preferred Contact if you cannot be reached:

_____
NAME PHONE #

TELL US ABOUT YOURSELF

I am: ☐ Student ☐ Employed ☐ Unemployed ☐ Retired
My preferred ways to communicate are (please check all that apply):
❑ American Sign Language
☐ Visual ☐ Tactile ☐ Close Vision ☐ Signed English
❑ Spoken English
If applicable, name/number preferred Interpreter:

_____

My preferred way to read is:

☐ **Print** ☐ **Large Print** ☐ **Braille** ☐ **Listening**

PROOF OF INCOME ELIGIBILITY

To be eligible for this federally funded program, your household income cannot exceed 400% of the federal poverty guidelines. **Please check one of the following requirements and provide support documentation to verify your income eligibility:**

- ❏ Federal Public Housing Assistance (Section 8)
- ❏ Medicaid
- ❏ Low-Income Energy Assistance Program/Pharmaceutical Assistance for the Aged and Disabled
- ❏ Temporary Assistance for Needy Families
- ❏ Supplemental Nutrition Assistance Program (Food Stamps)/PAAD
- ❏ SSI (Supplemental Security Income)
- ❏ SSDI (Social Security Disability Insurance) ***SSI/SSDI ONLY:***

Include letter stating this is your only source of income or include additional income sources

If you do not qualify for any of the programs listed above please provide:

- ❏ Federal Income Tax Return (full return required)

The 2020 income guidelines are listed below:

2020 Federal Poverty Guidelines	
Number of persons in family/household	**400% for everywhere, except Alaska and Hawaii**
1	**$51,040**
2	**$68,960**
3	**$86,880**
4	**$104,800**
For each additional person, add	**$17,920**

DISABILITY ELIGIBILITY

I am providing my most recent Audiogram: ☐ Yes ☐ No
I am providing my most recent Eye Report: ☐ Yes ☐ No
I am providing a letter from my doctor confirming a progressive diagnosis: ☐ Yes ☐ No
I am providing from a letter from a medical professional confirming my combined hearing and vision loss: ☐ Yes ☐ No

HISTORY

The cause of my hearing loss is:
☐ Born Deaf ☐ Lost hearing as a child ☐ Lost hearing as an adult

I would describe my level of hearing as:
☐ Deaf ☐ Hard of Hearing

I am currently using:
☐ Hearing Aids ☐ Cochlear Implant(s) ☐ Amplification Devices
***Please note this program does NOT purchase hearing aids or cochlear implants**

The cause of my vision loss is:
☐ Born Blind ☐ Lost my sight as a child ☐ Lost my sight as an adult

My hearing and/or vision is progressive: ☐ Yes ☐ No ☐ Unsure

I would describe my level of vision as
☐ Blind ☐ Low vision, please describe:

TELL US ABOUT YOUR CURRENT COMMUNICATIONS TECHNOLOGY EXPERIENCE

1. How do you make phone calls? (Check all that apply)

- ❑ Home phone
- ❑ Captel device
- ❑ Mobile phone Provider: _____
- ❑ Smart phone
- ❑ Relay service
- ❑ Facetime
- ❑ Other: _____
- ❑ Don't have access to making phone calls at this time
- ❑ Check here if any these devices were provided through the iCC Program

2. What device(s) and programs are you currently using? (Check all that apply)

- ❑ Desktop
- ❑ Laptop
- ❑ iPad/Tablet
- ❑ JAWS
- ❑ Zoomtext
- ❑ Alerting Devices
- ❑ Check here if these devices were provided through the iCC Program

3. In the last five years have you had computer training? ☐ Yes ☐ No

If yes, where did this training take place? (Check all that apply)

- ❑ iCanConnect
- ❑ One on one training through another program
- ❑ Public class
- ❑ Store (ex: apple/verizon)
- ❑ Family/Friend taught me

4. What is it that you can't do now that you would like to do?
(Check all that apply)

- ❑ **Have access to accessible equipment**
- ❑ **Learn about newer technology available**
- ❑ **Be able to communicate with family and friends**
- ❑ **Have access to email**
- ❑ **Be alerted when I have incoming calls/messages**

5. Are there any other technology needs you would like to share?

Release of Information

I authorize the New Jersey Commission for the Blind and Visually Impaired and The College of Jersey to share information regarding my application, assessment, and telecommunications needs.

❏ I also give them permission to communicate with anyone individual(s) and/or professional(s) listed in this application.

_____

Applicant Name

_____ _____

Signature **Date**

If applicant is under 18 years of age:

_____

Name of applicant

_____

Printed name of person signing on behalf of applicant

_____

Relationship to applicant

_____ _____

Signature **Date**

I am/or have been a client of NJ CBVI: ☐ Yes ☐ No

Department: ☐ Vocational Rehabilitation ☐ Independent Living ☐ Education

If yes, who is your primary contact:_____

Are you receiving services from a vision loss, hearing loss or deaf-blind professional?

Program/Contact person/Contact Information:

_____

Do you receive SSP Services? ☐ Yes ☐ No

Request for iCanConnect/NJ Services

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 Deaf-Blind Equipment Distribution Program).

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.

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This statement is required by the Privacy Act of 1974, Public Law 93-579, 5 U.S.C. 552a(e)(3).

_____ _____

Applicant Signature **Date**

If applicant is under 18 years of age

_____

Name of applicant

_____

Printed name of person signing on behalf of applicant/

_____

Relationship to applicant

_____ _____

Signature **Date**

RETURN THIS COMPLETED FORM TO

Did you include:

- ❑ **Signed Release of Information and Application**
- ❑ **Provide support documentation for hearing/vision loss**
- ❑ **Provide support documentation for income verification**

***We cannot determine eligibility if we do not receive all three of these items**

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If scanned documents are submitted, please use PDF format.

State of New Jersey
Department of Human Services
Commission for the Blind and Visually Impaired

The College of New Jersey
Center for Sensory and Complex Disabilities

OFFICIAL USE ONLY:

DATE RECEIVED:	**COMPLETED IN FULL:**
SUBMITTED:	**DEEMED ELIGIBLE:**